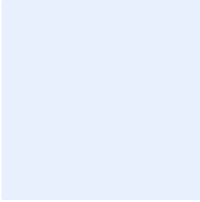

MENTAL HEALTH CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of . 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)

☐ 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
☐ ____________________
____

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

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	☐ You ☐ Family member (_______________)
Anemia	☐ You ☐ Family member (_______________)
Liver disease	☐ You ☐ Family member (_______________)
Chronic fatigue	☐ You ☐ Family member (_______________)
Kidney disease	☐ You ☐ Family member (_______________)
Diabetes	☐ You ☐ Family member (_______________)
Asthma/respiratory problems	☐ You ☐ Family member (_______________)
Stomach or intestinal problems	☐ You ☐ Family member (_______________)
Cancer	☐ You ☐ Family member (_______________)
Fibromyalgia	☐ You ☐ Family member (_______________)
Heart disease	☐ You ☐ Family member (_______________)
Epilepsy or seizures	☐ You ☐ Family member (_______________)
Chronic pain	☐ You ☐ Family member (_______________)
High cholesterol	☐ You ☐ Family member (_______________)
High blood pressure	☐ You ☐ Family member (_______________)
Head trauma	☐ You ☐ Family member (_______________)
Liver problems	☐ You ☐ Family member (_______________)
Other: _____________________	☐ 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:

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: ___________________

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: _________________	___________________________________

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? ______________________________

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 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?

ACKNOWLEDGMENT

Signature: ________________________ Date: ________________

Print Name: _______________________

Guardian Signature (if required) _____________________ Date: ________________

Print Name: _______________________

Emergency Contact: _______________________ Phone Number: _______________________