



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 | ☐ Fatigue | ☐ Excessive energy |
| ☐ Depressed mood | ☐ Suspiciousness | ☐ Decreased libido |
| ☐ Impulsivity | ☐ Loss of interest | ☐ Decreased need for sleep |
| ☐ Sleep pattern disturbance | ☐ Change in appetite | ☐ Crying spell |
| ☐ Avoidance | ☐ Anxiety attacks | ☐ _____ |
| ☐ Excessive worry | ☐ Excessive guilt | _____ |
| ☐ Forgetfulness | ☐ Increased risky behavior | |
| ☐ Unable to enjoy activities | ☐ Increased irritability | |
| | ☐ Increased libido | |
| | ☐ Hallucinations | |

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:

<u>Medication</u>	<u>Total Daily Dosage</u>	<u>Estimated Start Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Reason</u>	<u>Date Treated</u>	<u>By Whom</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Reason</u>	<u>Date Hospitalized</u>	<u>Where</u>
nini _____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Medication</u>	<u>Date</u>	<u>Dosage</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 her:

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:

<u>Age</u>	<u>Gender</u>
_____	_____
_____	_____
_____	_____
_____	_____

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: _____