Mental Health: Brief Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Social Security #: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. Emergency Contact Information.

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

3. Primary Insurance Information

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender
○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

4. Reason for today's visit:

_____

_____

_____

_____

5. I have a desire to proceed with therapy:

○ Yes ○ No

6. If no, please explain:

_____

_____

_____

_____

MEDICAL AND HEALTH HISTORY

7. How would you rate your physical health?
○ Excellent ○ Good ○ Fair ○ Poor

How would you rate your general sense of well-being?

_____

8. Please list any major medical conditions or surgeries you have/had:

_____

_____

_____

_____

9. List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Medication	Dosage	Reason for Taking?
1			
2			
3			

10. Do you have any known allergies?

○ Yes ○ No

11. If yes, please list any allergies:

	Allergic to?	Reaction
1		
2		
3		

12. Do you smoke?

○ Yes ○ No

13. If you smoke:

Packs/Day: Years:

14. Do you drink alcohol?

○ Yes ○ No

15. If you drink alcohol:

Drinks/Day: Years:

Have you ever felt a need to cut down on your drinking?

○ Yes ○ No

16. Do you drink caffeine?

○ Yes ○ No

If yes, Cups/day:

17. Do you use pain medication daily?

○ Yes ○ No

18. If yes, please list:

19. Do you use recreational drugs?

○ Yes ○ No

20. If yes, please list:

21. Have you been arrested?

○ Yes ○ No

22. If yes, explain:

23. Do you have any concerns about sleep?

○ Yes ○ No

24. Have you been diagnosed with a psychiatric condition?

○ Yes ○ No

25. If yes, what:

_____

_____

_____

_____

26. Have you received mental health service(s) in the past?

○ Yes ○ No

27. If yes, please list reason for treatment and dates:

_____

_____

_____

_____

28. Do you have (or have you had) any of these concerns:

	Answer	Notes/Comments
Difficulty falling or staying asleep		No
Sleeping too little or too much		No
Daily feeling of sadness that doesn't go away		No
Panic/Anxiety attacks		No
Problems concentrating		No
Mood fluctuates up and down		No
Remembering upsetting things constantly		No
Upsetting thoughts I can't get out of my head		No
Repetitive behaviors I can't stop		No
Constant worrying		
Disordered eating/purging		

Sexual Abuse		
Physical/Verbal Abuse		
Feeling tired almost every day		
Questions about sexual identity		
Feelings of low self-worth		
Risky behaviors		
Difficulty controlling my temper		
Difficulty maintaining a job		
Difficulty paying for basic expenses		
Thoughts of killing or harming myself		
Attempts to kill or harm myself		
Hear or see things that other people do not		

FAMILY PSYCHIATRIC HISTORY

29. Do you have a family (parent, sibling or child) history of:

	Answer	If yes, who?
Alcohol/Substance Abuse		
Anxiety		
Depression		
Eating Disorder		
Obsessive Compulsive Disorder		
Schizophrenia		
Suicide		
Other:		

If other, please specify: