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Mental Health Intake/Adult

DATE: _____

NAME: _____ **PROVIDER:** _____

DOB: _____ **RESOURCE:** _____

REASON FOR SEEKING THERAPY:

_____

_____

_____

_____

MENTAL HEALTH HISTORY (CHECK ALL THAT APPLY)

YES	NO	
☐	☐	HAS CLIENT HAD PRIOR OUTPATIENT PSYCHOTHERAPY?
☐	☐	HAS CLIENT HAD PRIOR INPATIENT TREATMENT FOR PSYCHIATRIC, EMOTIONAL OR SUBSTANCE ABUSE DISORDER?
☐	☐	HAS FAMILY MEMBER HAD OUTPATIENT PSYCHOTHERAPY? IF YES, WHO/WHY:
☐	☐	HAS FAMILY MEMBER HAD PRIOR INPATIENT TREATMENT FOR PSYCHIATRIC, EMOTIONAL OR SUBSTANCE ABUSE DISORDER? IF YES, WHO/WHY:
☐	☐	HAS CLIENT EVER USED PSYCHOTROPIC MEDICATIONS?
☐	☐	DOES CLIENT REPORT ANY SUICIDAL/HOMICIDAL IDEATIONS?
NOTES ON MENTAL HEALTH HISTORY:		

CURRENT SYMPTOMS CHECKLIST ***PLEASE CHECK SYMPTOMS PRESENT IN THE LAST 30 DAYS***

	YES	NO	COMMENTS/DESCRIPTION OF BEHAVIOR
AGGRESSION	☐	☐	
ANGER	☐	☐	
ANXIETY	☐	☐	
APPETITE DISTURBANCE	☐	☐	
BINGING/PURGING	☐	☐	
CONDUCT PROBLEMS	☐	☐	
DEPRESSION	☐	☐	
FATIGUE/LOW ENERGY	☐	☐	
FEAR/PHOBIAS	☐	☐	
GRIEF	☐	☐	
GUILT	☐	☐	
HOPELESSNESS	☐	☐	
HYGIENE ASSESSMENT			
HOW OFTEN DO YOU EAT?			

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How often do you shower?			
How often do you brush your teeth?			
Hyperactivity	☐	☐	
Irritability	☐	☐	
Mood Swings	☐	☐	
Panic Attacks	☐	☐	
Paranoia	☐	☐	
Physical Trauma	☐	☐	Was trauma reported? ☐ Yes ☐ No
Poor Grooming	☐	☐	
Poor Concentration	☐	☐	
Self-Mutilation	☐	☐	How often? History: Plan: Barriers to care:
Sexual Trauma	☐	☐	Was trauma reported? ☐ Yes ☐ No
Sleep Assessment			
Hours slept/night:			**Comments:**
Difficulty falling asleep?	☐	☐	
Difficulty staying asleep?	☐	☐	
Nightmares	☐	☐	
Social Isolation	☐	☐	
Uncontrollable Crying	☐	☐	
Worthlessness	☐	☐	

Family History

Present During Childhood:

	Yes	No	Describe Relationship
Father	☐	☐	
Mother	☐	☐	
Step-Father	☐	☐	
Step-Mother	☐	☐	
Brother/s	☐	☐	
Sister/s	☐	☐	
Grandparents	☐	☐	
Other (specify)	☐	☐	

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DESCRIBE CURRENT SIGNIFICANT ISSUES IN IMMEDIATE FAMILY RELATIONSHIPS:
NOTES ON CHILDHOOD
DESCRIBE MOTHER'S HEALTH/COMPLICATIONS DURING PREGNANCY OR BIRTH
DESCRIBE ANY DELAYS IN CHILDHOOD DEVELOPMENT

CLIENT'S SEXUAL HISTORY

✓	REPORTED	COMMENTS
SEXUAL ORIENTATION:		
SEXUAL EXPERIENCES:		
☐	NEVER IN A SERIOUS RELATIONSHIP	
☐	NOT CURRENTLY IN A RELATIONSHIP	
☐	CURRENTLY IN A SERIOUS RELATIONSHIP	

CLIENT'S MARITAL HISTORY

✓	REPORTED	COMMENTS
☐	SINGLE, NEVER MARRIED	
☐	ENGAGED	
☐	MARRIED	
☐	SEPARATED	
☐	DIVORCE IN PROCESS	
☐	DIVORCED	
☐	LIVING TOGETHER	
☐	PRIOR MARRIAGES (SELF)	
☐	PRIOR MARRIAGES (SPOUSE/PARTNER)	

CLIENT'S RELATIONSHIP/SATISFACTION

✓	REPORTED	COMMENTS
☐	VERY SATISFIED	
☐	SATISFIED	
☐	SOMEWHAT SATISFIED	
☐	DISSATISFIED	
☐	VERY DISSATISFIED	

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DESCRIBE CURRENT RELATIONSHIP:

PERSONS CURRENTLY LIVING IN CLIENT'S HOUSEHOLD

NAME	AGE	GENDER	RELATIONSHIP TO CLIENT

CLIENT'S CHILDREN NOT LIVING IN CLIENT'S HOUSEHOLD

NAME	AGE	GENDER	RELATIONSHIP TO CLIENT

DESCRIBE CURRENT LIVING SITUATION:

SOCIO-ECONOMIC HISTORY (CHECK ALL THAT APPLY)

SCHOOL & WORK

DESCRIBE SCHOOL GROWING UP:	
HIGHEST GRADE COMPLETED:	
MAJOR FIELD OF EMPLOYMENT:	
DESCRIBE CURRENT EMPLOYMENT:	
ARE YOU CURRENTLY EMPLOYED?	☐ YES, FULL TIME ☐ YES, PART TIME ☐ NOT EMPLOYED ☐ DISABLED
AVERAGE MONTHLY INCOME:	

FINANCIAL HISTORY

✓	REPORTED	COMMENTS
☐	NO CURRENT FINANCIAL PROBLEMS	
☐	RELATIONSHIP CONFLICTS OVER FINANCES	
☐	IMPULSIVE SPENDING	
☐	LARGE INDEBTEDNESS	
☐	POVERTY OR BELOW POVERTY INCOME	

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Housing

✓	Reported	Comments
☐	Adequate	
☐	Overcrowded	
☐	Dependent on others	
☐	Dangerous/Deteriorating	
☐	Living companions dysfunctional	
☐	Homeless	

Social Support

Describe Social Network/Support:
Describe hobbies and activities:

Cultural Background

Religious/Spiritual History (check all that apply)

✓	Reported	Comments
☐	Catholic	
☐	Protestant	
☐	Jewish	
☐	Spiritual	
☐	Other	

Describe any cultural or religious concerns:

Notes on socio-economic history:

Legal History (check all that apply)

List any past legal issues:
List any current legal issues:

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Military History (check all that apply)

✓	Reported	Comments
☐	Never in military	
☐	Served in military – no incident	
☐	Served in military – with incident	
☐	Honorable Discharge	
☐	Dishonorable Discharge	

Notes on Military History

Medical History (check all that apply)

Describe current physical health	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Primary Physician		**Phone Number**		
Psychiatrist (if any)		**Phone Number**		

Current Medications	Dosage	Reason

Prescribing Physician/s

Allergies:

Describe serious hospitalizations, surgeries or accidents:

Date	Description	Age	Reason

☐	Seizures	Dates of seizures:
☐	TBI	Describe
☐	Vision Issues	Describe

✓	Reported use/abuse	Comments
☐	No history of abuse	
☐	Active use/abuse	
☐	Addiction (active, remission, etc.)	

Any Abnormal Lab Results

Date	Result
Date	Result
Date	Result

Notes on Medical History:

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Family alcohol/drug abuse status		
✓	Reported	Comments
☐	Father	
☐	Mother	
☐	Grandparents	
☐	Sibling/s	
☐	Step-parent/s	
☐	Aunts/Uncles	
☐	Spouse/Significant other	
☐	Other	

Client's alcohol/drug abuse status				
✓	Reported use/abuse	First use (age/amount)	Current use (amount/frequency)	Comments
☐	Alcohol			
☐	Opiates			
☐	Amphetamines			
☐	Barbiturates			
☐	Benzodiazepines			
☐	Cocaine			
☐	Marijuana			
☐	Cigarettes			
☐	Caffeine			
☐	Other:			

Treatment History			
✓	Reported	Age/s	Comments
☐	Outpatient		
☐	Inpatient		
☐	12-Step Program		
☐	Stopped on own		
☐	Other:		