Mental Health Patient Intake Form

Contacts:
Legal (full) Name: *

Preferred Name/Pronouns:

Date of Birth: *

Address: *

Email address: *

Best phone number: *

EMERGENCY CONTACT
Who would you like us to contact in case of emergency? Please provide your emergency contact's name, phone number, and address: *

Relationship to Emergency Contact? *

Primary Care Physician and phone number:

Medical History: include dates if able
-Surgeries:

-Hospitalizations:

-Diagnosis:

-Medications/Over the counter medications/Herbals/Supplements/Vitamins:
-names/dosages

-Please list the date and place of your last physical exam or doctor visit: *

Psychiatric History:

Have you had previous psychiatric care? * ☐Yes ☐No. Include dates for the following if able

-Diagnosis:

-Medications:
-names/dosages:

-Hospitalizations:

-Suicide attempts:

-Have you ever received a psychological or neuropsych evaluation? ☐Yes ☐No

-Trauma:
Do you have a history of being abused (emotional, physical, sexual, financial, other)? *
If yes, please describe.

Have you experienced a traumatic event that impacted your life (for example-- divorce, natural disaster, major accident, loss of a loved one)? *If so, please describe.

Social History

On average, how many days per week do you exercise, and for how long per day, if applicable. *

Have you ever been diagnosed with or treated for an eating disorder? *☐ Yes ☐No
yes, please describe.

Do you have any concerns related to diet or exercise? ☐Yes☐ No

Have you recently gained or lost weight unexpectedly, and if so, how much have you gained/lost? *

Occupational and Educational History
Have you ever served in the military? *If yes, please describe where and when you were deployed.

Are you currently a (check all that apply): * Employed Student Unemployed Retired Disabled

What is your occupation? * Are you employed part-time or full-time? Please list your employer/school

Was school (grade school/college) difficult for you? *

What is your highest level of education? *

Relationships and Family
Relationship status: ☐Single ☐Married ☐Widowed ☐In a relationship
If you are in a relationship, for how long?

Gender identity: _____Gender at birth:_____ Sexual orientation:

Who do you currently live with? *

Do you have any children? If so, how many? *

Culture, Religion, and Spirituality
Please list any cultural, religious, or spiritual considerations you would like us to be aware of:

Stress
Rate your current level of stress from 1-10, 1 being none and 10 being the worst: *

What are your biggest stressors?

Substance Use History
How often do you drink alcohol and how much do you consume? *

In the past 3 months, what is the largest amount of alcoholic drinks you have consumed in one day? *

Do you think you may have a problem with alcohol or drug use, including prescription drugs?*

Do you use recreational or prescription medications other than as prescribed? *

Do you use any substances in a way other than the intended use (inhalants, whippets, etc.)?* if yes please list here:

If you answered yes to any of the 3 questions directly above, please specify the substance(s), how often, how much, and length of use:

Do you smoke (cigarettes, marijuana), use chewing tobacco, or vape? * If yes, please specify the substance, how much, and how long:

Do you consume energy drinks? ☐ Yes ☐ No
How many caffeinated beverages do you drink in a day? *

Legal History
Have you ever been arrested? * ☐ Yes ☐ No
Do you have any pending legal problems? * If yes, please describe.

ALLERGIES
Type:

Severity:

Reaction:

Have you ever been treated or diagnosed with any of the following:

☐ Diabetes ☐ Asthma ☐ Kidney disease ☐ Liver disease/problems ☐ High Blood Pressure ☐ Heart Disease ☐ Epilepsy or Seizures ☐ Head Trauma ☐ Anemia

☐ Stomach problems ☐ Chronic pain ☐ Fibromyalgia

Do you have any disabilities? * Yes No If yes, please describe.

Family Psychiatric and Medical History

Has anyone in your family been diagnosed or treated for any of the following? Check all that apply

☐ Heart disease ☐ High cholesterol ☐ Cancer ☐ Thyroid disease

☐ Sudden cardiac death before the age of 50

☐ Bipolar disorder ☐ Depression ☐ Anxiety ☐ Post-traumatic stress disorder

☐ ADHD ☐ Autism ☐ Schizophrenia ☐ Substance abuse ☐ Anger issues

☐ Suicide/suicidal ideation

Other

Is there anything not mentioned above that you would like us to know that might help us treat you best?

By signing below, I agree that the information in this form is correct to the best of my knowledge and that I will update the clinician about any changes necessary for treatment.

PATIENT SIGNATURE: *
PATIENT PRINTED NAME: *
Date: *