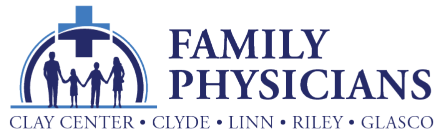

MENTAL HEALTH CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of Family Physicians. 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 INFORMATION (If you're in school, please fill out your school information, too.)

Name: ___________________________ **Today's Date**: _____________ **Birthday**: _______________

Primary Care Physician: ____

Do you give permission for ongoing regular updates to be provided to your primary care physician?
☐ Yes ☐ No

Current Pharmacy Name: ____

Current Therapist/Counselor: _________________________ **Therapist Phone**: _________________

School: ________________________ **Grade:** _______ **HR Teacher's Name:** ____________________

Receiving IEP or 504 at School? Why? ____

REASON FOR VISIT

What are the concern for which you are seeking help?

Current Symptoms: (check all that apply)

Racing thoughts		Suspiciousness		Excessive energy	
Depressed mood		Loss of interest		Decreased need for sleep	
Impulsivity		Anxiety attacks		Crying spell	
Sleep pattern disturbance		Excessive guilt		Others (Please describe)	
Avoidance		Increased risky behavior			
Excessive worry		Increased irritability			
Forgetfulness		Increased libido			
Unable to enjoy activities		Decreased libido			
Fatigue		Hallucinations			

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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

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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 inform? ☐ 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):

Diseases	You	Which Family Member
Thyroid disease		
Anemia		
Liver disease		
Chronic fatigue		
Kidney disease		
Asthma/respiratory problems		
Cancer		
Fibromyalgia		
Heart disease		
Epilepsy or seizures		
Chronic pain		
High cholesterol		
High blood pressure		
Head trauma		
Liver problems		
Others		

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 or abuse? ☐ 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: __________________	______________________

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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:

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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: ____________________

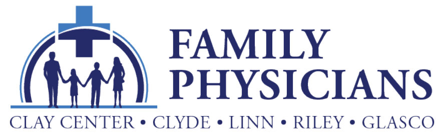
Marital status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
-How long have you been in your present status? ____________________
-If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long? ____________
-If you have a partner or spouse, what is their occupation? ____________________
-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	Name/Gender	Age	Name/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 of the group above helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐ More helpful ☐ Stressful

Is there anything else that you would like us to know?

Acknowledgement:

Signature: ____ Date: _________________________

Print Name: ____

Guardian Signature (if required) ________________________________ Date: _____________________

Print Name/Relationship with the client: ____

Emergency Contact: ______________________________ Phone Number: _______________________