Mental Health Intake Form

Name

First Name Last Name

Date of Birth

Month Day Year

Gender

Preferred pronouns

Nickname/Preferred Name

Email

Phone Number

Address

City

State

Zip Code

Primary Care Provider

Provider Phone Number

What are the problems for which you are seeking help?

Current Symptoms

- ☐ Depressed mood
- ☐ Excessive worry
- ☐ Impulsivity
- ☐ Sleep pattern disturbance
- ☐ Avoidance
- ☐ Increased libido
- ☐ Concentration/forgetfulness
- ☐ Suspiciousness
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Racing thoughts
- ☐ Unable to enjoy activities
- ☐ Anxiety attacks
- ☐ Increase risky behavior
- ☐ Loss of interest
- ☐ Hallucinations
- ☐ Decrease need for sleep
- ☐ Change in appetite
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Decreased libido

Other Symptoms

When did the symptoms start?

Use the scale to indicate severity of symptoms

◯ 0= None ◯ 1= Mild ◯ ◯ 3= Severe

Have you ever seriously considered ending your life?

◯ Yes ◯ No

If yes, please explain

Have you tried to hurt yourself in the past?

◯ Yes ◯ No

If yes, please explain

Have you ever been diagnosed with any mental health conditions?

◯ Yes ◯ No

If yes, please list

Mental Health Provider

Mental Health Provider Phone

Have you ever had inpatient psychiatric hospitalization?

◯ Yes ◯ No

If yes, please explain reason for hospitalization and dates

Please list any medications you have taken in the past for mental health concerns

Insurance Plan

Subscriber Name

Group Number

Subscriber ID

☐ **I do not have a participating insurance plan and will be paying private pay**

Emergency Contact

First Name **Last Name** **Relation** **Phone Number**

Medical History

Current Weight

Current Height

Please list any allergies and reaction

Do you have concerns about your physical health which you would like to discuss?

◯ Yes ◯ No

Current Medical Problems

Past Medical Problems, Hospitalizations, Surgeries

Current List of Medications

	Medication Name	Dosage	Estimated Start Date
1			
2			
3			
4			
5			
6			

Social History

Highest educational level reached

◯Some HS ◯HS ◯ Some college ◯Associate ◯Bachelors ◯Masters ◯PHD

Do you work outside of the home?

◯Yes Full-time ◯Yes Part-time ◯No

If yes, what do you do for work?

Have you served in the military?

◯Yes ◯No

Please select substances used

	Yes	No	How often?	How much?
Alcohol	◯	◯		
Nicotine	◯	◯		
Caffeine	◯	◯		
Marijuana	◯	◯		
Cocaine	◯	◯		
Benzodiazepines	◯	◯		
Heroin/Opioids	◯	◯		
Methamphetamine	◯	◯		

Please complete and email form to Psychiatry@mensmedical.health