3825 Henderson Blvd. Suite 405
Tampa, FL 33629
813.344.1671

Mental Health Intake Form

Personal Information

Name: ______________________ Date: ______________________
Address: ______________________
Phone: ______________________ Email: ______________________
DOB: ______________________ Sex: ______________________
Primary Physician: ______________________ Phone: ______________________
Psychologist: ______________________ Phone: ______________________
Psychiatrist: ______________________ Phone: ______________________

Complaint

Your major complaint(s)? ______________________
Start Date: ______________________ Have you previously suffered from this complaint? ______________________
Previous therapist(s) seen for complaint: ______________________
Previous treatment for complaint: ______________________
Aggravating Factors: ______________________
Relieving Factors: ______________________

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐	☐

Medical History

Exercise Frequency: ______________________ Exercise Type(s): ______________________
Allergies: ______________________
What medications are you currently using? ______________________
Previous diagnoses/mental health treatment: ______________________
Previously treated by: ______________________
Previous medications: ______________________
Dates treated: ______________________
Previous medical conditions: ______________________
Previous surgeries: ______________________

Family History

Were you adopted? ______________________ If yes, at what age? ______________________
How is your relationship with your mother? ______________________
How is your relationship with your father? ______________________
Siblings and their ages: ______________________
Are your parents married? ______________________
Did your parents divorce? ______________________ If yes, how old were you? ______________________
Did your parents remarry? ______________________ If yes, how old were you? ______________________
Who raised you? ______________________ Where did you grown up? ______________________
Family member medical conditions: ______________________
Family member mental conditions: ______________________
Treated with medication? ______________________
Medications: ______________________

Early Development

Where did you grow up? ____________________
How often did you move and where? ____________________
How old were you when you left home? ____________________
Have any immediate family members died? __________ Who? __________
Have any died by suicide? __________ Who? __________
Describe any neglect you suffered, and by whom: ____________________
Trauma suffered and by whom: ____________________
Abuse suffered and by whom: ____________________
Highest education level completed: ____________________
Date completed and location: ____________________
Have you ever served in the military? __________ If yes, where? __________
Dates of service: __________ Highest rank achieved: __________

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Are you married? __________ If yes, date of marriage: __________
Are you divorced? __________ If yes, date of divorce: __________
Prior marriages? __________ If yes, how many? __________
What is your sexual orientation? __________ Are you sexually active? __________
How is your relationship with your partner? ____________________
Do you have children? __________ Dates of Birth: __________
How is your relationship with your child(ren)? ____________________
List anyone else who lives with you: ____________________
Are you a member of a religion/spiritual group? ____________________
What is your level of involvement? ____________________
Have you ever been arrested? __________ When and why? __________

Have You Ever Tried the Following (Check All That Apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers

If yes to any, list frequency/dates of use: ____________________

Have you ever been treated for drug/alcohol abuse? __________ If yes, when? __________
For which substances? ____________________
Do you smoke cigarettes? __________ If yes, how many per day? __________
Do you drink caffeinated beverages? __________ If yes, how many per day? __________
Have you ever abused prescription drugs? If yes, which ones?

Anything Else You Want Me to Know

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____________________ ____________________
Signature of Client or Parent/Guardian Date

1/27/2020