Mental Health Intake

Client Name: _____ Date: _____

Check which of the following you have had in the past 6 months:

- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Depressed Mood
- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Fear
- ☐ Decreased Sleep
- ☐ Increased Sleep
- ☐ Relationship concerns
- ☐ Anger
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Increased alcohol consumption
- ☐ Racing thoughts
- ☐ Delusions
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Increased energy
- ☐ Trauma
- ☐ Loss
- ☐ Inability to focus
- ☐ Medical concerns
- ☐ Self-harming
- ☐ Tearfulness
- ☐ Legal problems
- ☐ Other _____

Briefly describe why you are seeking help at this time?

_____

_____

_____

Have you had any previous counseling? Y ____ N _____
If yes, who? _____
Name Phone Number

May we contact them? Y _____ N _____ (additional Release of Information needed to contact)

Describe any current or recurrent health problems you or your family may have?

_____

_____

List all medications in use (name, dosage, frequency, who prescribes them):

_____

_____

Any other information you would like the therapist to know:

_____

_____

_____

What is your general goal for counseling?

_____

_____

_____

Who referred you? _____