**Mental Health Intake & Evaluation**

**Patient Name:** Click here to enter text.

**Medical Record #:** Click here to enter text.

**Date of Birth:** select month select day select year

**Current Age:** Click here to enter text.

**Date Service Provided:** Click here to enter a date.

**Primary Care Provider:** Click here to enter text.

**Reason for Referral:**

**Medical History:**

|  |  |  |
| --- | --- | --- |
| headache  addiction  cardiac illness  hypertension | diabetes  sleep disorder  fertility issues  pregnancy loss | chronic pain  nutrition/obesity/eating disorder  other |

**Additional Comments:**

**Current Medications:** Click here to enter text.

**Mood** Issues (check all that apply)

|  |  |  |
| --- | --- | --- |
| Anger  Anxiety  Depression  Distress  Fatigue  lFlat | Guilt  Irritability  Mood Swings  Loss of Pleasure  Sadness | Suspicious  Tearful  Difficulty Concentrating  Withdrawn  Feel Worthless  Paranoid |

**Suicidal Ideation/Intentions:** select an option

Frequency of occurrence: Click here to enter text.

How long does it last: Click here to enter text.

Intensity of suicidal thoughts: Click here to enter text.

**Previous Therapy History?**

**Additional Comments:**