**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] Mood Swings[ ]  Loss of Pleasure[ ]  Sadness  | [ ] Suspicious[ ] Tearful[ ] Difficulty Concentrating[ ] Withdrawn[ ] Feel Worthless[ ] Paranoid |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:**