MENTAL MATTERS CLINICAL SERVICES, LLC

Marriage and Family Counseling
Substance Abuse Counseling
Individual Psychotherapy
Consulting

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status:

☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____) _____-_____ Cell/Other Phone: (_____)_____-_____

E-mail: _____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner, including name and phone Number:

_____

Are you currently taking any prescription medication?

☐ Yes Please list: _____

☐ No

Have you ever been prescribed psychiatric medication?

☐ Yes Please list and provide dates: _____

☐ No

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

☐ No

☐ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ No

☐ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

☐ No

☐ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly

☐ lnfrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle List Family Member

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weakness?

5. What would you like to accomplish out of your time in therapy?

Additional Information

Client's Name (please print) **Date**

Name of Parent or Guardian

_____

Signature of Patient/Parent/Guardian