Emergent Mental Health Services

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Intake Information Form

Please complete this confidential intake form to help me better understand you. Thank you!

Identifying Information:

Name: ___________________________________ **DOB:** _____________ **Age:** ___________

Address: ____**Apt:** ______

City: __________________________________ **State:** ______ **Zip Code:** __________

Occupation: _________________________________**Employer:** ________________________________

Ethnicity: ___________**Religion:** ____________**Language(s) Spoken in the Home:** __________________

Sexual Orientation: ____

Education: ____

Marital Status: __Single ___ Never Married ____Divorced ____Separated ____Widowed

Spouse's/Partner's Name: ________________________________ **Occupation:**______________________

Children and ages (if applicable): ____

____

Emergency Contact
Name: ____ **Phone Number:** _______________________

Relationship: ____

Referred to Therapy by: ____

Primary reason(s) for seeking services:
___Anger management ___Anxiety ___Depression ___Eating disorder ___Fear/phobias ___ Sexual concerns
___Sleeping problems ___Addictive behaviors ___Alcohol/drugs ___Inattention/Hyperactivity
___Trauma
___Other mental health concerns (specify):

Others Who Live in the Household

Name	Age	Relationship	Quality of relationship with you___
______________________	____	________________	___poor ___average ___good
______________________	____	________________	___poor ___average ___good

________________________ ____ _________________ ___poor ___average ___good
________________________ ____ _________________ ___poor ___average ___good
________________________ ____ _________________ ___poor ___average ___good
________________________ ____ _________________ ___poor ___average ___good

Comments:
____
____

Medical Information:

Name of Current Doctor: ____

Phone Number of Doctor: ____________________________________

Date of Last Physical Exam: ______________

Name of Psychiatrist (if applicable): ____

Previous Outpatient Therapist (if applicable): ____

Past Diagnosis (if applicable): ____

Please check off if you have been treated for any of the following:
___Asthma ___Auto-immune disorder (specify): ___________________
___Cancer ___Diabetes ___Eating Disorder ___Epilepsy (seizures) ___Eye Problem (specify): _____________
___Eye Problem (specify): ___________________ ___Headaches ___Heart Problem (specify): ______________
___Head Injury ___HIV Infection ___Infections ___Sickle Cell or Trait ___Overweight/Obsesity
___Other Medical Illness (specify): ____

Family Medical History:
Has anyone in your family ever been treated for any of the medical problems listed above? What medical problems run in the family (Both Parent's Side)? List who and what illness:
____
____
____

List Current Medications (Prescribed and Over the Counter):
____
____

List Allergies (medication, food, seasonal, etc):
____
____

List History of Hospitalizations (both medical and psychiatric):

Hospital	Date	Reason
___________________	__________________	_____________________________________
___________________	__________________	_____________________________________
___________________	__________________	_____________________________________

Changes in Your Behavior:

Have you noticed changes in the following behaviors/ areas in the last few weeks?
Sleep: ___ yes ___no
If Yes, Describe: ____
Appetite: ___ yes ___no
If Yes, Describe: ____
Mood: ___ yes ___no
If Yes, Describe: ____
Other changes:
____
____

Adult Behavioral Patterns or Presenting Problems/Current or Past Concerns:

(Please circle all behaviors/symptoms/reasons for referral that apply):

Anxiety	Daydreaming	Sleep problems
Depression	Disobedient	Drug/Alcohol use
Sadness	Stealing	Phobic
Angry	Low self-esteem	Rocking of body
Job/Career Issues	Talking to self	Recent illness
Relationship Issues	Fearful	Agression/Violence
Family Conflict	Irritable/Moody	Hearing voices
Impulsive	Worried	Fire Setting
Sexualized Language or Behavior	Loneliness	Mood swings
	Problems with Children	Homicidal or talk about wanting to kill others
Flashbacks	Sexual Issues	
Problems with School	Hyperactive	Suicidal or talks about wanting to die
Transition from Job/School	Short attention span	
Lying	Eating problems	Excessive time spent on computer or video games
Nightmares	Distractible	
Withdrawn	Self mutilating/Cutting	Obsessive or repetitive behaviors
Stubborn	Identity concerns	

Please elaborate on time frame, triggers, or precipitating factors to any of the above circled:
____
____

Changes in Your Life:

Check off any recent changes in your life or family's life:

__ Death of a loved one
__ Significant loss (family member, friend, etc.)
__ Conflict between others (family members, roommates, friendships)
__ Remarriage
__ Divorce or Separation
__ Change in living situation
__ Substance Abuse of parent, guardian, or sibling
__ Family member recently diagnosed with a mental health diagnosis
__ Loss of job
__ Incarceration of family member or other legal trouble
__ Serious illness or hospitalization of a family member
__ New Baby
__ Sibling moving away/going to college
__ Adoption
__ Foster Care
__ Traumatic Event (such as: fire, life threatening event, death, car accident, physical injury, domestic violence, child abuse, community violence, etc.):

____

____

Other:____

____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, Anxiety, Bi-polar disorder, suicide attempts, alcoholism, drug addiction, ADHD, PTSD Schizophrenia, etc.):

____

____

History of Abuse and Trauma

Physical Abuse:

Being abused by others: ____

Abusing others: ____

Sexual Abuse:

Being abused by others: ____

Abusing others: ____

Emotional Abuse:

Being abused by others: ____

Abusing others: ____

Domestic Violence:

History of domestic violence in your own relationship (past or current) or witnessing a family member's relationship (i.e., parents):

____

____

Outcome: ____

Family of Origin

Did you grow up with biological parents, adoptive parents, foster care, siblings, or other family living situation?

____

____

How would you describe your relationship with your family of origin?:

____

____

Relationship History

Are you satisfied with your frequency and quality of dating/romantic relationships?
___Yes ___No

If you are in a current relationship, how satisfied are you in this relationship?

____

____

Do you have any concerns about your current relationship?

____

____

If you identify as gay/lesbian/bisexual/transgender, have you come out to your family?
___Yes ___No ___N/A and if yes, how old were you when you came out?___________

If applicable, how did your family (and children if applicable) respond to your coming out?

____

____

Interests

What do you feel are your strengths?

____

____

What do you like to do for fun?

____

____

Who are you closest to in your life?

____

____

Therapy Goals and Treatment

Briefly describe your goals for therapy:

____

____

____

List any questions you have about therapy or services:

____

____

____