Mental Health Intake Form Template

Patient Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Taryn	Moore	Taryn	3857

Gender	Preferred Pronouns	Date of Birth	Marital Status
Female	She/her	19/07/1998	Single

Address	City	State	Zip Code
123 Anywhere St, Suburbia	Portland	OR	320

Email	Preferred Phone Number
example@email.com	000 0000

Emergency Contact

Full Name	Relationship	Contact Number
Gemma Moore	Mother	000 0000
Jake Moore	Brother	000 0000

Health and Medical Information

Primary Care Physician	Address	Contact Number
Dr Cameron Wilson	138 Street, Suburb	000 0000
Psychiatrist	Address	Contact Number
Dr Jane Turner	149 Street, Suburb	000 0000

Please list any medical conditions
MDD

Please list any current medication
Sertraline hydrochloride, 50mg/day

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Health4U	Plan B	00 0000
Policy Number	Group Number	Social Security Number
49458	30485	000 00 0000

Employment Status

- [x] Employed
- [ ] Self Employed
- [ ] Unemployed
- [ ] Other _____

Occupation	Industry	Company Name
Sales Consultant	Retail	BigTech Solutions

Company Address	City	State	Zip Code
123 Street, Suburb	Portland	OR	294

Availability

Please describe your availability throughout the week
Wednesdays, 3-6pm, and Fridays 9-12pm

Patient Information

First Name	Last Name	Date of Birth	Gender
Taryn	Moore	19/07/1998	Female

Personal History

Do you have a current mental health diagnosis? If so, please specify.

Yes, moderate major depressive disorder. Have been diagnosed since 2020.

Do you have a past mental health diagnosis? If so, please specify.

Previously thought to be generalised anxiety disorder, however, this was revised.

Do you exercise regularly?

Yes, twice a week.

How much time a day do you exercise?

One hour a day.

Please select any of the following symptoms that you have

☑ Depressed Mood	☐ Suspiciousness	☐ Crying Spells
☐ Excessive Worry	☐ Excessive Energy	☑ Loss of Interest
☐ Impulsivity	☐ Increased Irritability	☐ Hallucinations
☑ Sleep Pattern Disturbance	☐ Increased Risky Behaviors	☑ Decreased need of sleep
☐ Avoidance	☐ Racing Thoughts	☐ Change in Appetite
☐ increased Libido	☑ Unable to Enjoy Activities	☐ Excessive Guilt
☐ Concentration/Forgetfulness	☐ Anxiety Attacks	☑ Fatigue
☐ Decreased Libido	☐ Other:	

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)

Signature of Patient, Parent or Guardian	Date
	12/12/2022