Mental Health Intake Form Template

Patient Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status
Address	City	State	Zip Code
Email	Preferred Phone Number		

Emergency Contact

Full Name	Relationship	Contact Number
Full Name	Relationship	Contact Number

Health and Medical Information

Primary Care Physician	Address	Contact Number
Psychiatrist	Address	Contact Number

Please list any medical conditions

Please list any current medication

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

Employment Status

◯ Employed ◯ Self Employed ◯ Unemployed ◯ Other _____

Occupation	Industry	Company Name
Company Address	City	State	Zip Code

Availability

Please describe your availability throughout the week

Patient Information

First Name	Last Name	Date of Birth	Gender

Personal History

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

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

Do you exercise regularly?

How much time a day do you exercise?

Please select any of the following symptoms that you have

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

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