Adult Mental Health Intake Form

Today's Date:
Client Name:
DOB:
Location of treatment:
Treatment provider:
What problems or concerns brought you to counseling?
Do you have a history of mental health symptoms? Please describe, including the history of your symptoms including any past or present suicidal thoughts or actions.
Have you been in counseling before? Please list dates/providers of past services.
Have you been hospitalized for psychiatric reasons before? Please list dates and reasons for hospitalization, as well as location if possible.

List all current medications:

When was the last time you used drugs or alcohol?

Describe any history of substance abuse, including substances and dates.

Describe your eating and exercise habits.

Who is your primary care doctor?

When was your last visit?

Do you have any other doctors or agencies you regularly work with? Please list them.

Describe your family of origin. (Who did you grow up with? What was the family dynamic? Who are you close to or estranged from now?)
List any family history of medical or mental health problems.
What is your current living situation? (Rent, own, unstable housing, etc) Who lives with you?
What is your work situation? (Full-time, part-time, student, unemployed) What is the highest grade you have completed?
List your social supports (including church, friends' first names, family, etc)

What do you like to do for recreation/fun?
What is your spiritual background? Describe your current engagement with religion or faith.
What are your personal strengths and growth areas? Strengths: Growth Areas:
Any other concerns?
Provider Use Only:
ICD-10 Diagnosis: 1. 2. 3.

Clinical Formulation:
Treatment Provider Signature:
Date: