38600 Van Dyke Ave., Suite 200 Sterling Heights, MI 48312
Phone: (586) 933-5395 Fax: (586) 935-0159
www.HopeinCounseling.com

Mental Health Intake Form

Full Name:_______________________________________ Date of Birth: ____________ Age: _______

Address:____City/State/Zip ________________________

Phone Number: _______________________ Email Address:___________________________________

Do you give us permission to contact you through text/call/email: Yes or No

Emergency Contact:________________________________ Relationship:_________________________

Phone Number of Emergency Contact: _________________________

Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Middle Eastern ☐Prefer not to answer

How would you identify your sexual orientation?
☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual ☐ unsure ☐ other ☐ Prefer not to answer

What are the problem(s) for which you are seeking help?

1. _________________________________ 3. _________________________________

2. _________________________________ 4. _________________________________

Current Symptoms Checklist:

☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry ☐ Excessive guilt ☐ Increased irritability ☐ Avoidance

☐ Unable to enjoy activities ☐ Impulsive ☐ Anxiety Attacks ☐ Tired ☐ Crying spells ☐ Loss of interest ☐ Hallucinations

☐ Sleep Disturbance ☐ Increase risky behavior ☐ Decrease need for sleep ☐ Increased libido ☐ Decreased libido

☐ Change in appetite ☐ Excessive energy ☐ Concentration/forgetfulness

When did these symptoms start: ____

How often do you have these symptoms: ____

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? Yes or No

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? Yes or No

When was the last time you had thoughts of dying? ____

How often do you have these thoughts? ______________________________

Has anything happened recently to make you feel this way? ______________________________

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? ________

Would anything make it better? ______________________________

Have you ever thought about how you would kill yourself? ______________________________

Is there anything that would stop you from killing yourself? ______________________________

Have you ever tried to kill or harm yourself before, If so, when? ______________________________

Do you have access to guns? If yes, please explain. ______________________________

Past Psychiatric History:

Outpatient Treatment: Yes or No If yes, please describe when, by whom, and nature of treatment.

Reason/ Dates / Treated By Whom: ______________________________

Psychiatric Hospitalization: Yes or No If yes, describe for what reason, when and where.
Reason/ Date / Hospitalized Where: ______________________________

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? Yes or No

Please describe when, where and by whom: ______________________________

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:
☐ Bi-polar Disorder ☐Schizophrenia ☐ Depression ☐ PTSD ☐ Anxiety ☐ Substance Abuse
☐ Other Mental Illness (please list) ______________

If yes, who had each problem? ______________________________

Has anyone in your family or social circle attempted or committed suicide? If yes, please state who: ________

____

Medical History:
Please list any medical problems: ______________________________

Allergies: ______________ Weight: __________ Height: ________

Please list any and all medication you are currently taking:

Medication Name	Dosage	Reason

Substance Use:

Have you ever been treated for alcohol or drugs? Yes or No If yes, for which substances? ________________

If yes, where were you treated and when? ____

How many days/week do you drink alcohol ____________ How many drinks do you consume on average: _________

In the past three months, what is the largest amount of alcoholic drinks you have consumed in 1 day? ______________

Do you think you may have a problem with alcohol or drug use? Yes or No

Have you used any street drugs in the past 3 months? Yes or No If yes, which ones ___________________________

Have you ever abused prescription medication? Yes or No If yes, which ones/how long___________________

Check if you have ever tried the following:

☐Methamphetamine (Past/Current)
☐Cocaine (Past/Current)
☐Stimulants (pills) (Past/Current)
☐Heroin (Past/Current)
☐LSD or Hallucinogens (Past/Current)
☐Marijuana (Medical or Recreational) (Past/Current)
☐Pain killers (not prescribed) (Past/Current)
☐Methadone (Past/Current)
☐Tranquilizer/sleeping pills (Past/Current)
☐Alcohol (Past/Current)
☐Ecstasy(Past/Current)
☐Other ______________________________

Tobacco History:

Have you ever smoked cigarettes? Yes or No

Currently? Yes or No Packs/Day on average? _______________ How many years? ____________________

How many years did you smoke? _______ When did you quit?___________ Why? ______________________________

Family Background and Childhood History:

Describe your relationship with your spouse or significant other: ______________________________________

Have you had any prior marriages? *Yes* or *No* If so, how many? ____

Do you have children? *Yes* or *No* If yes, list names & ages: ____

Describe your relationship with your parents: ____

In your family, are you: ☐ Only Child ☐ Oldest ☐ Middle ☐ Youngest

Describe your relationship with your siblings:____

Did your parents' divorce? Yes or No If so, how old were you when they divorced? ___________________

If your parents divorced, who did you live with? ____

Who do you go to for support? ____

Development History:

Please list any developmental delays or missed milestones, if any: ______________________________

Educational History:

Highest Grade Completed__________ Did you attend college? Yes or No

What is your highest educational level or degree attained? ______________________________

Occupational History:

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

What is/was your occupation? ______________________________

Employer ______________________________

Legal History:

Have you ever been arrested? Yes or No

Do you have any pending legal problems? Yes or No If yes, please describe: ______________

Will you need your therapist to author letters/reports regarding any pending legal cases? Yes or No

Strengths/Limitations:

Please list any strengths of limitations you have which may help us to personalize your treatment:__________

____

I attest that the information I have provided is true and accurate, to the best of my ability/knowledge.

Signature ______________________________ Date: ___/____/_______

Guardian Signature (if under age 18): ______________________ Date: ___/____/_______

For Office Use Only:

Therapist Signature: ______________________________Date ______________________