Marcy Houston
Mental Wellness Center of the Lowcountry

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly.

Name:_____ Date: _____

Date of Birth:_____

Contact number:_____ Do you give permission for therapist to leave a message at this number? YES NO

What are the problem(s) for which you are seeking help?
1)_____
2)_____
3)_____

Current Symptoms Checklist: (check for any symptoms present)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/ forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive Worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

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

How often do you have these thoughts?_____

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

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

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

_____

Have you ever thought about how you would kill yourself_____

Is the method you would use readily available?_____

Have you planned a time for this?_____

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

Do you feel hopeless and/or worthless?_____

Have you ever tried to kill or hame yourself before?_____

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

Medical History:

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Name of prescribing physician	Total Daily dosage

Current over-the-counter medications or supplements:

_____

_____

Current medical problems:

_____

_____

Psychiatric History:

Outpatient treatment ( ) YES ( ) No If yes, Please describe when, by whom, and the nature of treatment.

Reason	Dates Treated	By Whom

Have you ever been hospitalized for psychiatric reasons? ( ) YES ( ) NO If yes, Please describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

( ) Bipolar disorder ( ) Schizophrenia ( ) Depression

( ) Anxiety ( ) Anger ( )Suicide

( ) Post-Traumatic Stress ( ) Alcohol abuse ( ) other substance abuse

( ) Violence

If yes, who had each problem?

_____

_____

_____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up?_____

List your siblings and their ages:

_____

_____

What is your father's name and occupations?_____

What is your mother's name and occupation?_____

Did your parents divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

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

What is your relationship with your family?

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or neglect?

( )Yes ( ) No if so, by whom? _____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? ( ) Yes ( ) No Where? _____ Major:_____

What is your highest educational level or degree attained?_____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation?_____

Where do you work?_____

Have you ever served in the military? ( ) Yes ( ) No If so, what branch and when?

_____

Honorable discharge ( ) Yes ( ) N0 Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed

How long?_____

If not married, are you currently in a relationship? ( ) Yes ( ) No

How would you identify your sexual orientation?_____

What is your spouse or significant others name?_____

What is your spouse or significant other's occupation?_____

Have you had any prior marriages? ( ) Yes ( ) No If so, how many?_____

Do you have Children? ( ) Yes ( ) No If yes , list names, ages and gender

Name Age Gender

_____

_____

_____

_____

Describe your relationship with your family?

_____

_____

List everyone who currently lives with you:

_____

_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems?_____

Spiritual Life:

Does religion or spirituality play a role in your life?_____

Do you belong to a particular religion or spiritual group?_____

In what do you find strength or hope?_____

Hobbies:

What do you do and with whom do you spend your free time?

_____

_____

What do you do to manage stress?

_____

_____

Your Exercise Level:

Do you exercise regularly? ( ) YES ( ) NO

How many days a week do you get exercise?_____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

How many caffeinated beverages do you drink a day? _____

Have you ever smoked or used chewing tobacco? ( ) Yes ( ) NO Currently? ( ) Yes ( ) NO

How many packs per day on average? _____ How many years?_____

Is there anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date:_____

Guardian Signature (if under age 18) _____ Date:_____

Emergency Contact: _____ Telephone #: _____

For Office Use Only:

Reviewed by: _____ Date:_____