MCS Counseling Group, LLC

Youth Mental Health Intake Form

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

Name: _____ Date: _____
Gender: _____ Pronouns used: _____ Race/Ethnicity: _____
Birthdate: _____ Primary Care Physician: _____

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

1. _____
2. _____
3. _____

What are your treatment goals?

1. _____
2. _____
3. _____

Past Psychiatric History:

Have you ever seen a counselor/therapist before? ( ) yes ( ) no If **YES,** please describe below.

Reason	Dates Treated	By Whom (or agency)

Have you been hospitalized for mental health reasons? ( ) yes ( ) no If **YES,** please describe below.

Reason	Dates Hospitalized	Hospital

Have you experienced trauma such as witnessing or experiencing a deeply, distressing, upsetting, or disturbing event? ( ) No ( ) Yes, explain.

_____
_____
_____
_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:
(if YES please indicate which relative - mother, father, etc.)

Bipolar	( ) No ( ) Yes _____	Schizophrenia	( ) No ( ) Yes _____
Depression	( ) No ( ) Yes _____	Post-traumatic stress	( ) No ( ) Yes _____
Anxiety	( ) No ( ) Yes _____	Alcohol Abuse	( ) No ( ) Yes _____
Suicide	( ) No ( ) Yes _____	Other Substance Abuse	( ) No ( ) Yes _____
Autism	( ) No ( ) Yes _____	Violence/anger	( ) No ( ) Yes _____
ADHD	( ) No ( ) Yes _____		

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Current Symptoms Checklist:

( ) Feeling like a burden
( ) Unable to enjoy activities
( ) Sleeping too little/too much
( ) Feeling trapped
( ) Concentration problems
( ) Forgetfulness
( ) Change in appetite
( ) Extreme mood swings
( ) Other: _____

( ) Expressing hopelessness
( ) Impulsivity
( ) Gender/Sexual identity
( ) Defiant
( ) Excessive guilt
( ) Excessive energy
( ) Excessive worry
( ) Flashbacks

( ) Anxiety attacks
( ) Avoidance
( ) Anxiety
( ) Increase of anger
( ) Pushing others away
( ) Crying spells
( ) Aggression
( ) Fatigue

List **ALL** medical conditions past and present:

Allergies:_____

Surgeries:_____

Injuries:_____

Other:_____

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

Medication Name	Daily Dosage	Reason Prescribed	Prescribing Doctor	Start Date

Current over the counter medications or supplements:

_____

_____

_____

Substance Use:		If **YES,** how long and when did you last use?
Methamphetamine	( ) No ( ) Yes	_____
Cocaine	( ) No ( ) Yes	_____
Stimulants (pills)	( ) No ( ) Yes	_____
Heroin	( ) No ( ) Yes	_____
LSD/Hallucinogens/Mushrooms	( ) No ( ) Yes	_____
Marijuana	( ) No ( ) Yes	_____
Pain killers (not prescribed)	( ) No ( ) Yes	_____
Methadone	( ) No ( ) Yes	_____
Tranquilizer/sleeping pills	( ) No ( ) Yes	_____
Alcohol	( ) No ( ) Yes	_____
Ecstasy	( ) No ( ) Yes	_____

How many caffeinated beverages do you drink a day (please write number of beverages a day)?

Coffee: _____ Sodas:_____ Tea:_____ Energy Drink:_____

Tobacco History:

Do you use cigarettes?	( ) No ( ) Yes, how much/often? _____
Do you use a Vape/E-Cig/Juul?	( ) No ( ) Yes how much/often? _____
Chewing Tobacco or Pipe, cigars	( ) No ( ) Yes how much/often? _____

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Current Family and Relationship History:

Are you: ( ) Single ( ) In a relationship

Who are your friends/other social support?

_____

_____

List everyone who lives with you and their relationship with you:

_____

_____

Family of Origin:

Who raised you? _____

Where did you grow up? _____

How many siblings do you have? (biological, step, half, adopted, foster?)

_____

_____

Education:

School: _____ Grade: _____

IEP: ( ) No ( ) Yes 504 Plan: ( ) No ( ) Yes

School issues: ( ) No ( ) Yes, explain:

_____

_____

_____

_____

Legal History:

Have you ever been arrested? ( ) No ( ) Yes Do you have pending legal problems? ( )No ( ) Yes

If yes, please provide dates: _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) No ( ) Yes

If yes, what is the level of your involvement?

_____

_____

_____

Do you find your involvement helpful during this time frame, or does the involvement make things more difficult or stressful for you? ( ) More helpful ( ) Stressful

What are you confident in?

_____

_____

What are you not so confident in?

_____

_____

Is there anything else that you would like your therapist to know? For example: symptoms, difficult relationships, stresses, or frustrations.

_____

_____

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Suicide Risk Assessment:

History of Self Harm:

( ) Cutting ( ) Burning ( ) Scratching ( ) Biting ( ) Head Banging ( ) Skin Picking ( ) Hair Pulling ( ) Other: _____

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

If **YES**, please answer the following.

Do you currently feel that you don't want to live? ( ) No ( ) Yes

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? _____

What would make it better? _____

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 have feelings of hopelessness and/or worthless? _____

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

*Do you have access to guns? If **YES,** please explain:* _____