MCS Counseling Group, LLC

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: _____ Gender:_____

Pronouns used:_____ Race/Ethnicity:_____

Birthdate: _____ Primary Care Physician: _____

Current Occupation: _____ Highest level of education completed: _____

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? ( ) No ( ) Yes, please describe below.

Reason	Dates Treated	By Whom (or agency)

Have you been hospitalized for mental health reasons? ( ) No ( ) 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:

( ) Depressed Mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbances
( ) Loss of Interest
( ) Concentration problems
( ) Forgetfulness
( ) Change in appetite
( ) Increased irritability
( ) Decreased libido
( ) Nightmares
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Seizures
( ) Decreased need for sleep
( ) Excessive energy
( ) Fatigue
( ) Flashbacks
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Head injury
( ) Suspiciousness
( ) Excessive guilt
( ) Crying spells
( ) Other: _____

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: ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Single ( ) In a relationship
Prior marriages? ( ) No ( ) Yes, how many? _____
Children? ( ) No ( ) Yes, how many? (please indicate bio, step, adopted)

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?)

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:

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:* _____