MENTAL HEALTH INTAKE FORM

Client Name: ______________________ Date of Birth: __________

Address: ______________________

Phone Number: ______________________ Email: ______________________

Emergency Contact Name: ______________________

Emergency Contact Phone: ______________________

Insurance Information:

Insurance Provider: ______________________

Policy Number: ______________________

Group Number: ______________________

Presenting Problem / Reason for Seeking Services:

Describe your main concerns, symptoms, or issues you are experiencing:

____

____

____

Mental Health History:

Have you ever received mental health counseling or therapy before? Yes [ ] No [ ]

If yes, please describe:

____

____

Medical History:

Current Medications:

____

Allergies:

____

Major Illnesses, Hospitalizations, or Surgeries:

____

Substance Use History:

Do you currently use or have used alcohol or drugs? Yes [ ] No [ ]

If yes, please specify:

I hereby consent to receive mental health treatment and understand that all information shared during therapy sessions will be kept confidential according to applicable laws and ethical standards, except as required by law (such as in cases of harm to self or others, abuse, or court orders). I acknowledge that I have been informed of my rights and responsibilities. I understand that I may revoke this consent at any time in writing, but such revocation will not affect actions taken before receipt of the revocation.

CLIENT'S SIGNATURE	**THERAPIST'S SIGNATURE**
Printed Name:	Printed Name:
Date:	Date:
Signature: __________________________	Signature: __________________________

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