Veronica San Juan, LMFT

Mental Health Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Primary Physician: _____ Phone: _____

Referred by: _____

Reason for Visit

Reason for visit: _____

Start Date: _____ Have you previously suffered from this? _____

Mild / Moderate / Severe Symptoms (circle one)

Previous therapists seen for this reason: _____

Aggravating factors: _____

Relieving factors: _____

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐ Suicide Ideations/Attempts	☐ Other: _____

Medical History

Allergies: _____

What medications are you currently using? _____

Previous diagnoses / mental health treatments / hospitalizations: _____

Previously treated by: _____

Previous medications: _____

Dates treated: _____

Previous medical conditions: _____

Previous surgeries: _____

Previous substance use: _____

Family History

Were you adopted? _____ If yes, at what age? _____

How is your relationship with your mother? _____

How is your relationship with your father? _____

Siblings and their ages: _____

Are your parents married? _____

Did your parents divorce? _____ If yes, how old were you? _____

Did your parents remarry? _____ If yes, how old were you? _____

Who raised you? _____ Where did you grow up? _____

Family member medical conditions: _____

Family member mental conditions: _____

Family member substance use: _____

Have any immediate family members died? _____ Who? _____

Have any committed suicide? _____Who? _____

Describe any neglect you suffered, and by whom: _____

Abuse suffered and by whom: _____

Highest education level completed: _____

Date completed and location: _____

Have you ever served in the military? _____ If yes, where? _____

Present Situation

Work: ☐ Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Are you married? _____ If yes, date of marriage: _____

Are you divorced? _____ If yes, date of divorce: _____

Prior marriages? _____ If yes, how many? _____

Anything else you want the therapist to know:

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACT INFORMATION

Dependent? _____ If yes, guardian's name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's name: _____

Spouse's employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

INSURANCE

Insured Party: _____ Relationship to patient: _____

Insurance Company: _____ Phone No. _____

Address: _____

Policy No. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to patient: _____

Phone No. _____ Address: _____

Policy No. _____ Group No. _____

Payment Method: _____ Card / Check No. _____

I verify that the above information is factual and true to the best of my knowledge. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Date