Cooper
Therapy Connections PLLC
Speech Therapy, Evaluations, Counseling and Feeding Therapy
(779) 234-8997

MENTAL HEALTH INTAKE FORM

TODAY'S DATE: _____

CLIENT NAME: _____ NICKNAME:_____

DOB: _____AGE: _____ ☐ Male ☐ Female

Home Address: _____ City, State, Zip: _____

Phone:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email:_____

Primary Physician:_____ Phone:_____

Current Therapist:_____ Phone:_____

CURRENT STATUS

Please describe your present affliction(s):

Estimated date affliction(s) occurred:_____

Have you previously suffered from these afflilction(s)? ☐YES ☐NO

Previous therapist(s) seen for affliction(s):_____

Previous treatment for affliction(s):_____

Aggravating Factors:_____

Relieving Factors:_____

CURRENT SYMPTOMS (Check All That Apply)

☐Anxiety	☐Appetite Issues	☐Avoidance	☐Guilt
☐Depression	☐Excessive Energy	☐Fatigue	☐Libido Changes
☐Hallucinations	☐Impulsivity	☐Irritability	☐Risky Activities
☐Loss of Interest	☐Panic Attacks	☐Racing Thoughts	
☐Sleep Changes	☐Suspiciousness	☐Crying Spells	

MEDICAL HISTORY

Exercise Frequency:_____ Exercise Type:_____

Allergies:_____

What medications are you currently using?

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

FAMILY HISTORY

Were you adopted? ☐YES ☐NO If yes, at what age?_____

Describe your relationship with your mother:

Describe your relationship with your father:

Siblings and their ages:

Did your parents divorce? ☐YES ☐NO If yes, how old were you?_____

Did your parents remarry? ☐YES ☐NO If yes, how old were you?_____

Who raised you?_____

Family member medical conditions:

Family member mental conditions:

Were the above conditions treated with medication? ☐YES ☐NO

If yes, list medications, if known:

Have any immediate family members died? ☐YES ☐NO If yes, who?_____

Have any committed suicide? ☐YES ☐NO If yes, who?_____

EARLY DEVELOPMENT

Where did you grow up?_____

How often did you move and where? _____

How old were you when you left home?_____

Describe any neglect you suffered, and by whom:_____

Trauma suffered and by whom:_____

Abuse suffered and by whom:_____

EDUCATION & PRESENT SITUATION

Highest education level completed:_____

Date completed and location:_____ Area of study:_____

Have you ever served in the military? ☐YES ☐NO If yes, where?_____

Dates of service:_____ Highest rank achieved:_____

Current work: ☐Full-Time ☐Part-Time ☐Student ☐Unemployed ☐Disabled ☐Retired

Occupation:_____

Are you married? ☐YES ☐NO If yes, date of marriage:_____

Are you divorced? ☐YES ☐NO If yes, date of divorce:_____

Prior marriages? ☐YES ☐NO If yes, how many?_____

What is you sexual orientation?_____ Are you sexually active? ☐YES ☐NO

Describe your relationship with your partner:_____

Do you have children? ☐YES ☐NO If yes, how many?_____ Ages:_____

Describe your relationship with you child(ren):_____

List anyone else who lives with you:_____

Are you a member of a religion/spiritual group? ☐YES ☐NO If yes, describe:_____

What is your level of involvement?_____

Have you ever been arrested? ☐YES ☐NO If yes, when and why?_____

HAVE YOU EVER TRIED THE FOLLOWING? (Check all that apply)

☐Alcohol	☐Tobacco	☐Marijuana	☐Hallucinogens (LSD)
☐Heroin	☐Methamphetamines	☐Cocaine	☐Stimulants (Pills)
☐Ecstasy	☐Methadone	☐Tranquilizers	☐Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? ☐YES ☐NO If yes, when?_____

For which substances?_____

Do you smoke cigarettes? ☐YES ☐NO If yes, how many per day?_____

Do you drink caffeinated beverages? ☐YES ☐NO If yes, how many per day?_____

Have you ever abused prescription drugs? ☐YES ☐NO If yes, which ones?_____

ADDITIONAL INFORMATION IMPORTANT FOR THE THERAPIST TO KNOW:

What are you hoping to get out of our services?

Goals you want to accomplish:

Person filling out the form: _____

Signature:_____ Date:_____

Relationship to the client: _____