Divine Innovation Therapy
Receive the Personalized Care You Deserve

Mental Health Intake Form

Personal Information

Name: DOB: Sex: Date:

Address:

Email:

Phone:

Phone:

Primary Physician:

Current Therapist:

Complaints

What is your major complaint?

Start Date:

Have your previously suffered from this complaint?

Previous therapist(s) seen from complaint:

Previous treatment for complaint:

Aggravating Factors:

Relieving Factors

Current Symptoms (Mark all that apply)

Symptoms	None	Mild	Moderate	Severe	Symptoms	None	Mild	Moderate	Severe
Depressed Mood					Increased/decreased appetite				
Social Isolation					Unplanned weight gain or loss				
Dissociation (zoning out)					Cruelty to animals				
Hyperactive					Paranoid thoughts				
Purging (throwing up)					Poor concentration or indecisive				
Nightmares					Over-exercising				
Unresolved Guilt					Excessive worrying				
Crabby Moods					Impulsive action/speech				
Nausea					Anger management problems				
Social Anxiety					Vandalism/stealing				
Self-mutilation/cutting					Hallucinations				
Low self-worth					Racing Thought				
Developmental delays					Restlessness				
Truancy (skipping school)					Loss of interest in normal actives				

Symptoms	None	Mild	Moderate	Severe	Symptoms	None	Mild	Moderate	Severe
Losing train of thought					Lying				
Mood Swings					Soiling/wetting				
Disorganized					Easily Distracted				
Anorexia					Memories of Trauma				
Drug experimentation					Hopelessness				
Grief					Poor grades/ problems at school				
Phobia's					Panic Attacks				
Smoking cigarettes					Feeling panicky/anxious				
Bullying/being bullied					Suicidal thought				
Problems at home					Attempted suicide in the past				
Viewing Pornography					Problems with parents				
Sleep disturbance					Physical complaints				

Medical History

Exercise Frequency:

_____

Exercise Type(s)

Allergies:

_____

What Medication are you currently using?

_____

Previous diagnosis/mental health treatment:

_____

Previously treated by:

_____

Previous medications:

_____

Dates treated:

_____

Previous medical conditions:

_____

Previous surgeries:

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 get a divorce? If yes, how old were you?

_____

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

_____

Who raised you?

Family member medical conditions:

Family member medical conditions:

Treated with medication?

Medications:

Early Development

Where did you grow up?

How often did you move and where?

How old were you when you left home?

Have any immediate family members died? Who?

Have any committed suicide? Who?

Describe any neglect you suffered, and by whom:

Trauma Suffered and by whom:

Abuse suffered and by whom:

Higher education level completed:

Dates completed and location:

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

Date of service: Highest rank achieved:

Have You Ever Tried the Following (Check All That Apply)

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

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

Have you ever been treated for drug/alcohol abuse?

For which substances

Do you smoke cigarettes?

Do you drink caffeinates beverages?

Have you ever abused prescription drugs?

Anything else you want the doctor to know

Signature:_____

Date: _____