Mental Health Intake Questionnaire

Please complete this questionnaire as accurately as possible. This information is confidential and will help us understand your needs.

1. Personal Information

Full Name:	
Date of Birth (MM/DD/YYYY):	
Gender/Pronouns:	
Phone Number:	
Email Address:	
Street Address:	

2. Emergency Contact

Contact Name:	
Relationship to You:	
Contact Phone:	

3. Reason for Visit

What are the primary reasons you are seeking support today?

Please list any specific symptoms you are experiencing (e.g., anxiety, depression, sleep issues):

How long have you been experiencing these challenges?

4. Mental Health & Medical History

Have you ever received mental health services before? (Yes/No and detail):

Are you currently taking any psychiatric or medical medications? (List names and dosages):

Please list any major medical conditions or physical concerns:

5. Social & Lifestyle History

Describe your current support system (e.g., family, friends, community groups):

Are you currently experiencing any major life stressors (e.g., work, financial, relationship)?

What are your personal goals for therapy?

6. Signature & Date

Client Signature (or Printed Name): _____ Date: _____