Mental Health Outpatient Intake and Assessment Form

Instructions: Please complete all sections as accurately as possible. This form is intended for clinical intake and print record-keeping.

1. Patient Demographics

Full Name: ______ Date of Birth (MM/DD/YYYY): ______

Gender/Pronouns: ______ Marital Status: ______

Phone Number: ______ Email Address: ______

Street Address: ______

Emergency Contact Name: ______ Relationship: ______ Emergency Phone: ______

2. Referral Information & Presenting Problem

Referral Source (Who referred you to this clinic?): ______

Primary Reason for Seeking Help (Chief Complaint): ______

Onset and Duration of Current Symptoms: ______

3. Psychiatric and Medical History

Previous Mental Health Diagnoses (if any): ______

Previous Psychiatric Hospitalizations (Dates and Locations): ______

Current Psychiatric Medications (Names and Dosages): ______

Current Medical Conditions (e.g., diabetes, high blood pressure): ______

Primary Care Physician Name and Contact: ______

4. Substance Use Assessment

Alcohol Use (Frequency and Quantity): ______

Tobacco/Nicotine Use (Type and Frequency): ______

Recreational Drug Use (Substance, Frequency, and Method): ______

5. Risk Assessment

Current Suicidal Ideation (Yes/No, details if Yes): ______

Past Suicide Attempts (Dates and Details): ______

Current Homicidal Ideation or Intent to Harm Others (Yes/No, details if Yes): ______

History of Self-Harm Behaviors (e.g., cutting): ______

6. Family and Social History

Family History of Mental Illness or Substance Abuse:

Current Living Situation (Who do you live with?):

Employment / Educational Status:

7. Mental Status Examination (Clinician Use Only)

Appearance (e.g., neat, disheveled, appropriate):

Behavior/Activity (e.g., calm, agitated, tremors):

Speech (e.g., normal rate/volume, pressured, slurred):

Mood and Affect (e.g., euthymic, depressed, anxious, labile):

Thought Process (e.g., linear, circumstantial, tangential):

Thought Content (e.g., delusions, obsessions, hallucinations):

Cognition/Orientation (e.g., alert and oriented x4, distracted):

Insight and Judgment (e.g., good, fair, poor):

8. Clinical Impression and Diagnostic Summary

Provisional Diagnosis / DSM-5 Codes:

Clinical Summary Notes:

9. Treatment Recommendations and Plan

Recommended Treatment Modality (e.g., Individual CBT, Group Therapy):

Frequency of Services (e.g., weekly, bi-weekly): Estimated Duration of Treatment:

Initial Treatment Goals:

10. Signatures

Patient/Guardian Signature: Date:

Clinician/Assessor Signature & Credentials: Date: