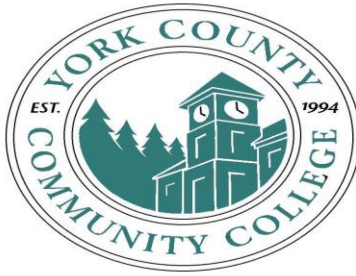

York County Community College

Mental Health Intake Form

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION Date:___________________________

Last Name:_________________________________ First Name:___________________MI______

Street Address:___________________________________Apt or Box #:_______________________

City_________________________________State_____________ZIP___________County_________

Home Phone Number (_____) ___________________Cell Phone Number (_____) _____________

Work Phone Number (_____) ______________________ Date of Birth___/___/_____; Age:____

Gender:___ Male ____Female____ Transgender ____Gender Expansive

Name of Health Insurance:____

Employer:___________________________________Address:________________________________

Email Address:____

Referred by: ☐ Self ☐ Family/Friend ☐ School ☐ Physician

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other________

Ethnicity: ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander ☐ Other: _______________

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed/looking for work ☐ Student ☐Retired ☐ Disabled ☐ Other: _______________

Emergency Contact: __________________________ Relationship to Client:________________________ Phone:_________

SECTION II: FAMILY/HOME INFORMATION

How many dependents do you have? (Include yourself)________________________________

Children	Age	Living at Home?

List other people living in the home besides those named above:

Name	Age	Relationship

Are your parents divorced? Yes____ No____

Do you have guns in your home? Yes____ No_____

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Briefly describe the problem that brings you to counseling services today:

____

____

____

How can we help you with this? What do you want to work on in counseling and change?

____

____

____

How long has it been a significant problem?____

In the past, what has been helpful to you in dealing with this problem?_____________________

____

How would you estimate the severity of the problem: Mild_____ Moderate_____ Serious_____ Severe_____

SECTION IV: MEDICAL/HEALTH INFORMATION

Treatment History:

Have you received mental health treatment before? ☐ Yes ☐ No

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatments and results:

Therapist/Hospital	Dates	Phone	Initial Reason	Outcome

Please check any of the following that you have experienced recently:

☐ Depression	☐ Anxiety	☐ Voices/visions	☐ Suicide
☐ Panic attacks	☐ Paranoia	☐ Appetite problems	☐ Stealing
☐ Compulsive behaviors	☐ Weight loss/gain	☐ Racing thoughts	☐ Running away
☐ Sleep problems	☐ too much energy	☐ Poor attention	☐ Social withdrawal
☐ Anger	☐ Distractibility	☐ Irritability	☐ Low energy
☐ Aggression/violence	☐ Poor concentration	☐ Blackouts	☐ Hyperactivity
☐ Memory problems	☐ Other(s) ________________		

It is very important for your counseling treatment that we are able to have contact with your primary care provider (PCP). Do you give your permission for us to contact your PCP?
☐ Yes ☐ No

Who is your primary doctor/medical provider?

____

Name City Phone number

What medications do you take? (Include non-prescription, herbal medicines and supplements)

Medicine	Dose	Frequency	Who prescribes

Please list any allergies, including medication allergies/sensitivities:

____

____

Date of your last exam:____

Please list any significant health or medical or psychiatric issues, including any resulting in hospitalization

Dates	Problem and Treatment	Were you hospitalized Y/N

Suicide Attempt/s or Violent Behavior:

Age	Reason	Circumstance	How

Abuse/Trauma History: ☐ I was not abused in any way ☐ I was abused

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Substance Use:

Have you been treated for alcohol/drug problems before? ☐ Yes ☐ No
If so, when and

where____

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers, benzo's				
Painkillers, oxy's, opiates				
Heroin				
Coffee				
Cigarettes				
Alcohol				
Stimulants Adderall Meth				
Hallucinogens LSD/Mushroom/PCP				
Use Laxatives				
Crack, Coke, Ecstasy, Bath Salts				
Inhalants				
Synthetic Cannabis (spice)				
Sleeping pills				
Muscle Relaxer				
Other				

Alcohol Use:

Have you ever felt the need to cut down on your drinking? __ No __ Yes

Have you ever felt annoyed by criticism of your drinking? __ No __ Yes

Have you ever felt guilty about your drinking? __ No __ Yes

Have you ever taken a morning "eye-opener"? __ No __ Yes

How much beer, wine, or hard liquor do you consume each week, on average?

____

How much tobacco do you smoke or chew each day?____

What have been some problems associated with these substances that you have experienced?

____

____

____

Have any members of your family had problems with: Drugs____ Alcohol____ Mental Illness____

How much time outside of academic work do you spend on the internet per day?_______

SECTION V: SOCIAL RELATIONSHIP STATUS

Among friends and family who do you depend on for support?________________________

Are you: Single____Dating____Married/Partnered____Divorced/unpartnered____Widowed/ a surviving partner____

Friendships, Community & Spirituality – describe quality, frequency, activities

____
____
____

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:

____
____
____

What gives you the most joy or pleasure in your life?

____
____
____

What are your main worries and fears?

____
____
____

What are your most important hopes and dreams?

____
____
____

Is there anything else we need to know to assist you?