



Patient Intake Form - Adult (MH)

Name: _____ Date: _____

In order to provide you with the service you expect, we need to begin with information from you. Please complete the following:

Briefly describe your reason for obtaining service:

Have you received treatment for this issue or problem in the past? Yes _____ No _____

Please provide dates of treatment and name of provider who has treated you:

Inpatient

Out- Patient

What is the name of your primary care physician?

Physician: _____ Telephone: _____

Please list any medications you are currently taking: _____

Please Complete the Next Page

Patient Name: _____

Please list any health (medical) problems for which you have recently been treated:

Please list any serious health (medical) problems you have had in the past:

Please describe below any special concerns, questions, or information you believe will be helpful in developing your treatment program:

Please complete the following page as honestly as possible. Thank you.