Manhattan Psychology Group, PC
107 West 82nd St Suite P101
New York NY 10024
646-389-4112

Mental Health Intake Questionnaire: Adult

Patient's name:

Patient's date of birth:

Patient's address:

Patient's cell:

Patient's email:

Which most closely describes the patient's gender?:

Sex assigned at birth:

Pronouns:

Race/Ethnicity:

Highest level of education:

Employer and Occupation:

Emergency contact name/relationship:

Emergency contact's phone number:

Referred by name:

Referred by specialty:

Psychological Concerns and Treatment

Current Concerns

What is the primary concern?:

Is the patient currently receiving, or have they received treatment, for this concern within the past year?:

- [ ] Yes
- [ ] No

If yes, please check all other professionals seen for this concern within the past year (Check all that apply)

- [ ] Inpatient Treatment
- [ ] Therapist (outpatient mental health professional)
- [ ] Psychiatrist
- [ ] Neurologist
- [ ] Other

If other, please list the type of professional seen:

Current Symptoms (Check all that apply):

- [ ] Feeling sad or down, extreme feelings of guilt or crying spells
- [ ] Confused thinking, reduced ability to concentrate, difficulty starting or completing tasks
- [ ] Excessive energy, hyperactivity, impulsivity or racing thoughts
- [ ] Excessive fears or worries or panic attacks
- [ ] Extreme mood changes or irritability
- [ ] Loss of interests or withdrawal from friends and activities
- [ ] Significant tiredness, low energy, fatigue or problems sleeping
- [ ] Detachment from reality, paranoia, suspiciousness or hallucinations
- [ ] Inability to cope with daily problems or stress
- [ ] Trouble understanding and relating to situations and to people
- [ ] Risky activity or substance (alcohol or drug) use

- [ ] Major changes in eating habits or appetite
- [ ] Excessive anger, hostility or violence
- [ ] Suicidal thinking, self-harm, intrusive thoughts of death or dying
- [ ] Sex drive changes
- [ ] Other

If other, please specify:

Please provide additional information about the patient's current concern:

History of Psychological Treatment

Prior Psychiatric Evaluations?: ☐ Yes ☐ No

If yes, please provide the type/s of evaluation/s, the evaluator/agency, and date of evaluation/s:

Prior Psychological Diagnosis(es): ☐ Yes ☐ No

If yes, please provide the diagnosis/es, professional(s) that diagnosed, and the date(s) of diagnosis/es:

Prior Psychiatric Treatment?: ☐ Yes ☐ No

If yes, please provide the name the treatment provider/agency, dates of treatment, and description of treatment:

Medical History

What medication(s) is the patient CURRENTLY prescribed (please include the name(s) of the medication(s), the dose(s), name(s) of prescriber(s), the date(s) the patient started it, and the reason for taking it)?:

What medications have been prescribed in the past year that are NO LONGER taken (please include the name(s) of the medication(s), the dose(s), name(s) of prescriber(s), the date(s) the patient started it, and the reason for taking it)?:

Please list any medical conditions that the patient is CURRENTLY being treated for:

Please list previous medical conditions that the patient is NO LONGER being treated for:

Please list any major surgeries (prior and pending):

Any other significant medical history?:

Family Structure and History

Marital Status:
- ☐ Married (and not separated)
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Other

If other, please specify:

If married, please specify date of marriage:

If divorced, please specify date of divorce:

Has the patient had prior marriages?: ☐ Yes ☐ No

If yes, how many?:

Who lives in the home (please include names, ages, and relation to patient)?:

Where did the patient grow up (city, state, and years residing in each)?:

Languages spoken at home:

Family history of psychiatric difficulties; list relation to patient and diagnosis (i.e. brother - anxiety):

Present Situation

Does the patient have children?:	☐ Yes ☐ No
If yes, please provide more information and describe their relationship with their child(ren):	
Is the patient a member of a religion/spiritual group?:	
Has the patient ever been arrested?:	☐ Yes ☐ No
If yes, when and why?:	

Substance Abuse History

Does the patient have any experience with the following?

- ☐ Alcohol
- ☐ Tobacco
- ☐ Hallucinogens (LSD)
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain killers

If yes to any of the above, please provide additional information including dates and frequency:

Has the patient ever been treated for drug/alcohol use? ☐ Yes ☐ No

If yes, when?:

Does the patient smoke cigarettes? ☐ Yes ☐ No

If yes, how many per day?:

Does the patient drink caffeinated beverages? ☐ Yes ☐ No

If yes, how many per day?:

Has the patient ever abused prescription drugs? ☐ Yes ☐ No

If yes, which ones?:

Additional Information

Please feel free to provide any additional information that the patient would like the therapist to know.

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