Mental Health Intake Medical History Form

Personal Information

Full Name

Date of Birth

Phone

Email

Address

Emergency Contact

Name

Relationship

Phone

Presenting Concerns

Reason for seeking support

Medical & Mental Health History

Current Medications

Medical Conditions

Past Mental Health Diagnoses / Concerns

Family History of Mental Health Concerns

Lifestyle Information

Substance Use (alcohol, tobacco, drugs)

Sleep Pattern

Exercise

Other Information

Anything else you'd like to share