TRUE Mental Health & Wellness, PLLC
Trust. Rapport. Understanding. Encouragement.
15 Dawn Road, Suite 2, Pinehurst, NC 28374 | O:910-585-6108 F:910-475-1666 |
truemhw@gmail.com | truemhw.com

GENERAL INTAKE FORM

GENERAL INFORMATION

Patient Name:_____

Prefers to be called:_____ Date of Birth:_____

Address:_____

Phone Number:_____Email:_____

May we (Please check all that apply):

☐ Call you for appointments, reminders and other therapeutic information?	☐ Leave a message with a member of your family?
☐ Leave a message on your voicemail?	☐ Send a text message regarding appointment reminders?

Patient Gender (Please check one)

☐ Woman
☐ Man
☐ Transgender
☐ Non-binary/Non-conforming
☐ Prefer not to respond

Patient Ethnicity (Please check one)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Prefer not to respond

Insurance Type:_____Insurance ID#_____

How did you hear about us?

_____

What is your major complaint?

_____

CURRENT SYMPTOMS
(check all that apply)

☐ Anger	☐ Guilt or Shame	☐ Mood Swings
☐ Anxiety	☐ Hallucinations	☐ Overwhelmed
☐ Appetite Issues	☐ Headaches	☐ Panic Attacks
☐ Avoidance	☐ Helpless	☐ Racing Thoughts
☐ Crying Spells	☐ Impulsivity	☐ Risky Activities
☐ Depression	☐ Irritability	☐ Sleep Changes
☐ Excessive Energy	☐ Libido Changes	☐ Worthlessness
☐ Fatigue	☐ Loss of Interest or Pleasure	☐ Thoughts of Harming Self or Others

MEDICAL HISTORY

Who is your Primary Care Provider?

_____

Current physical health concerns/medical conditions:_____

_____

Previous surgeries:_____

Allergies:_____

Current medications: (If needed, use back of page to complete additional medications)

NAME	DOSAGE	FREQUENCY

Have you ever been inpatient hospitalized for psychiatric reasons? YES / NO
If YES, please provide date(s), hospital(s) and reason for hospitalization:

Have you seen a therapist/counselor in the past? YES / NO
If YES, please provide therapist(s) name(s) and date(s) seen:

Are you currently pregnant? YES / NO

IMMEDIATE FAMILY HISTORY
(grandparents, parents, siblings, children)

What is your current relationship status?
☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ In a relationship
☐ Widowed
☐ Prefer not to respond

SUBSTANCE USE HISTORY

Have you ever tried the following other than prescribed? (Check all that apply)

☐ Alcohol	☐ Ecstasy	☐ Marijuana/Cannabis
☐ Barbiturates	☐ Hallucinogens (LSD)	☐ Methamphetamines
☐ Benzodiazepines	☐ Heroin	☐ Nicotine
☐ Cocaine	☐ Inhalants	☐ Opiates

If you checked any of the above, list frequency/dates of use:_____

Have you ever been treated for drug/alcohol abuse? YES / NO
If YES, please provide place and dates of treatment:_____

Do you currently or in the past used tobacco products or vaped? YES / NO
If YES, how much do you use per day?
_____

Do you currently use alcohol?
(Please check which best describes your use)
☐ Not at all
☐ holidays, special occasions
☐ 2-4 times a month
☐ 2-3 times a week
☐ 4 or more times a week

Do you drink caffeinated beverages? YES / NO
If YES, how many drinks per day do you consume?
_____

SOCIAL HISTORY

Do you consider yourself spiritual/religious?

_____

Work Status
(check all that apply)

☐ Employed Full Time	☐ Employed Part Time	☐ Unemployed
☐ Disabled	☐ Retired	☐ Student
☐ Military/Veteran/1st Responder	☐ Other:_____	

Education Level
(check one)

☐ Less Than High School	☐ GED	☐ High School Diploma
☐ Some College	☐ Associates Degree	☐ Trade School
☐ Bachelors Degree	☐ Masters Degree	☐ Doctoral Degree

Who lives in the home with you?

_____

Do you have children? If so, please list their age(s):_____

Do you have any siblings? YES /NO

How is your relationship with them?

_____

Do you feel you have a good support system? YES / NO

What are some things you enjoy doing?:_____

_____

Do you have any legal charges pending against you? YES / NO

Minors: What school are you attending and the grade?:_____

TRAUMA HISTORY Have you experienced any of the following?
(Check all that apply)
☐ Physical Abuse ☐ Verbal Abuse ☐ Financial Abuse ☐ Sexual Abuse
☐ Mental / Emotional Abuse
Do you or an immediate family member have a history of violence? YES / NO
Do you or an immediate family member have a history of suicidal attempts? YES / NO
If YES, please list if self/other; and if other, their relationship to you:_____

Have you ever experienced loss of consciousness or a traumatic brain injury (TBI)? YES / NO

If yes, please state how long you lost consciousness (if applicable), what caused your injury, and any symptoms you still suffer from:

Have you been involved in a serious accident, illness, medical procedure?
OR exposed to, witnessed a serious traumatic event?
If so, please provide date(s) and briefly describe:

ADDITIONAL

Is there anything else you want the therapist to know?:

Thank you very much for taking the time to complete this information!