Mental Health Intake Checklist

Please indicate how often you have experienced each of the following symptoms over the past two weeks:

Symptoms	Never	Rarely	Sometimes	Often	Always
Feeling sad or depressed					
Loss of interest or pleasure in activities					
Feelings of worthlessness or guilt					
Difficulty sleeping or sleeping too much					
Feeling restless or unable to sit still					
Fatigue or loss of energy					

Difficulty concentrating or making decisions					
Thoughts of death or suicide					
Feeling anxious or worried					
Panic attacks or sudden feelings of intense fear					
Avoiding situations or places because of anxiety					
Flashbacks or nightmares					
Intrusive thoughts or images					
Obsessive or compulsive behaviors or thoughts					

Feelings of anger or irritability					
Difficulty controlling anger					
Engaging in risky or impulsive behaviors					
Substance use or abuse					
Eating disorders or disordered eating habits					
Difficulty managing stress					
Relationship or family problems					
Difficulty with work or school					

Physical symptoms such as headaches or stomachaches					

Please answer the following questions:

1. Have you ever been diagnosed with a mental health disorder?

A. Yes

B. No

2. Are you currently taking any medication for a mental health disorder?

A. Yes

B. No

3. Have you ever been hospitalized for a mental health disorder?

A. Yes

B. No

4. Have you ever seen a mental health professional before?

A. Yes

B. No

5. What are your goals for psychotherapy? (please check all that apply)

A. Improve mood
B. Reduce anxiety
C. Improve relationships
D. Manage stress
E. Increase self-awareness

F. Address past traumas
G. Improve self-esteem
H. Improve coping skills

I. Other (please specify): _____