

# INTAKE INFORMATION – MENTAL HEALTH



**Vicki J. Hutman, LLC**  
**Sports and Performance Psychology**  
**Mental Health and Wellness**

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Today's Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DOB: \_\_\_\_\_

Marital Status: \_\_\_\_\_ (S) \_\_\_\_\_ (M/LP) \_\_\_\_\_ (D) \_\_\_\_\_ (W) \_\_\_\_\_ (Sep)

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Educational Level Completed: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Spouse/Partner Ethnicity \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## **PERSON RESPONSIBLE FOR PAYMENT (if different from patient)**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SSN \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## **Background Information:**

1. **What are your major areas of concern?** \_\_\_\_\_

2. Have you received any counseling/therapy in the past? Yes No

Where? \_\_\_\_\_

3. Do you have any medical problems? Yes No

If you answered yes, what are they: \_\_\_\_\_

4. List any medications you are currently taking: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

5. List the names and ages of the members of your immediate family:

Name	Age	Name	Age
Parent _____	_____	Child _____	_____
Parent _____	_____	Child _____	_____
Spouse _____	_____	Child _____	_____
Other _____	_____	Child _____	_____
Brother _____	_____	Sister _____	_____
Brother _____	_____	Sister _____	_____

I was referred by: \_\_\_\_\_

**Family History**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Abuse History**

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**Substance Use**

Caffeine

Alcohol

Tobacco

Other

Substance Abuse Treatment History

Family History/Substance Abuse

**Family History Mental Illness:**

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**Mental Status Exam**

Appearance

Orientation

Thought Content

Thought Process

Speech

Motor

Intellect

Insight

Judgment

Impulse Control

Memory

Concentration

Attention \_\_\_\_\_ Behavior \_\_\_\_\_

Appetite/Weight Change \_\_\_\_\_

Sleep \_\_\_\_\_

Energy Level \_\_\_\_\_

Memory \_\_\_\_\_

Concentration \_\_\_\_\_

Recreation \_\_\_\_\_

Self-care \_\_\_\_\_

Suicidal Ideation \_\_\_\_\_

Hx of Attempts \_\_\_\_\_

**ADDITIONAL INFORMATION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DIAGNOSIS**

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Stressors: \_\_\_ Work \_\_\_ Family \_\_\_ School \_\_\_ Medical \_\_\_ Other

GAF: Current \_\_\_\_\_ Highest Last Year \_\_\_\_\_

**TREATMENT GOALS**

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**TREATMENT PLAN**

**Modality**

**Frequency**

**Duration**

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**Referrals Made:**

- 1.
- 2.
- 3.

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Date