MENTAL HEALTH EVALUATION
INTAKE FORM

Date: _____

Client's Full Name _____ **Alias or Other Name**(s) I have used _____

Reason(s) for other name(s) I have used _____

Date of Birth _____ **Place of Birth** _____ **Social Security** _____

Race: I am __ Black __ Caucasian __ Asian **Citizenship**: I am a citizen of _____ I am also a citizen of _____

Sexuality: I am __ Male __ Female __ Transsexual __ Transgender __ Hermaphroditic

Sexual Orientation: I am __ Heterosexual __ Homosexual __ Bisexual __ Asexual __ Pan-sexual __ Other _____

Marital Status: __ Single __ Engaged __ Married __ Divorced __ Widowed __ Separated **Number of Marriages**: ___

Additional Family Members: _____ Relationship: _____ Current Age: ____
_____ Relationship: _____ Current Age: ____
_____ Relationship: _____ Current Age: ____
_____ Relationship: _____ Current Age: ____
_____ Relationship: _____ Current Age: ____

Home Address: _____ City _____ Zip _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Leave Message at Home? Yes __ No __ **Leave Message at Work**? Yes __ No __

In Case of Emergency Contact Name/Phone Number: _____

E-mail Address: _____ **Web-page**: _____

Facebook: _____ **Skype**: _____

Referred by: _____ **Phone**: _____

Physician: _____ **Phone**: _____

Psychiatrist: _____ **Phone**: _____

Attorney: _____ **Phone**: _____

Probation Officer: _____ **Phone**: _____

Education: High School _____ Year _____ Location _____

Trade School _____ Year _____ Certification _____

College/University _____ Year _____ Major _____ Degree ____

_____ Year _____ Major _____ Degree ____

_____ Year _____ Major _____ Degree ____

I am currently enrolled at _____

My educational goal is _____

Have you ever filed for bankruptcy? Yes ___ No___ Have you ever been involved in a lawsuit? Yes ___ No___

Have you ever been incarcerated? Yes ___ No___ Have you ever had an abortion Yes ___ No___

Have you ever been in a relationship with someone who has had an abortion? Yes ___ No___

What was your relationship with them?_____

Disabilities: Type:_____ Degree of:_____

Type:_____ Degree of:_____

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Current Weight: ____ **Height**: ____ **Eye color**: _____ **Hair color**: _____ ☐ Right Handed ☐ Left Handed ☐ Both

☐ **Tattoos** ☐ **Body Modifications** ☐ **Piercings** ☐ **Scars** ☐ **Prosthetic** _____

Primary Language: _____ **Other Languages spoken**: _____

Previous Therapy? Yes __ No __ **Former Therapist**: _____ Approximate date: _____

Previous Mental Health Evaluation: Yes __ No __ **Evaluator**: _____ Date: _____

I was raised primarily by:

☐ Biological Mother & Father ☐ Biological Father only ☐ Biological Mother only
☐ Father & Step-Mother ☐ Mother & Step-Father ☐ Elder Sibling
☐ Maternal Grandparent(s) ☐ Paternal Grandparent(s) ☐ Aunt/Uncle
☐ Foster Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parents in ___ homes

In my family of origin I was: ☐ first born/only child ☐ first born of ___ ☐ 2nd born of ___
☐ 3rd born of ___ ☐ 4th born of ___ ☐ other_____

My biological parents' names: Father _____ Mother (maiden name) _____

My biological parents' cultural origins or ethnicity: (e.g. Italian, English, German, Russian, French)

Father _____ Mother_____

My primary foster/adoptive parents' cultural origins were:

Father _____ Mother_____

The primary wage-earner(s) during my childhood was/were employed as:

☐ Father _____ ☐ Mother _____
☐ Step-Father_____ ☐ Step-Mother _____
☐ Other person and occupation_____

Religiously, I describe myself as:

___ Agnostic ("god" is unknown or unknowable)
___ Against a belief in in any "god" and/or any religion
___ Believing in a higher power, with no affiliation
___ Believing in a higher power, with affiliation _____
___ Believing in God as described in the Bible
___ Believing in Allah as described in the Koran
___ Atheistic (there is no "god")
___ Theistic (there is a "detached god")

Religious Background: _____

Church, Temple, Synagogue or Mosque currently attending: _____
Location: _____ Clergy or Religious leader: _____

My military experience was:

☐ I never served in the military
☐ I served __ years in the (branch of service) _____
☐ I was discharged Type of discharge _____
☐ I am retired
☐ I served in combat __ Number of tours Where _____
My military specialty (MOS) is/was _____ My rank is/was _____ The type of Discharge _____

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My current marital status is:

- ☐ Never been married and not living with anyone in a committed relationship
- ☐ Never been married, but in a committed relationship (at least two years) ☐ engaged
- ☐ married, and living with my spouse (full name) _____
  Spouse's age ___ spouse's occupation _____
  Number of prior marriages _____ Dates of Separations or Divorces _____
- ☐ Separated and living alone, or with someone in a platonic relationship
- ☐ Separated, and living with someone in a committed relationship
- ☐ Widow/widowed, and living alone or with a family member _____Date spouse deceased

My income over the past 12 months (or 12 months prior to incarceration) was:

- ☐ less than $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $30,000
- ☐ 30,001 to $40,000 ☐ $40,001 to $50,000 ☐ $50,001 to $60,000
- ☐ 60,001 to $70,000 ☐ $70,001 to $80,000 ☐ $100,000 plus
- ☐ Disability income of $_____ ☐ Social Security Income $_____
- ☐ Other Income $_____

My employment history:

- ☐ Unemployed____ months/years
- ☐ Retired_____ years
- ☐ Employed

  Employer's Name: _____ Supervisor's Name: _____

  Employer's Address: _____

  Job Title: _____ Length of time employed: _____

CONSENT TO EVALUATION

I, the undersigned, request and give consent to a forensic evaluation by

Dr. Harry L. Morgan, Ph.D., LMHC, CCSOTS, CFMHE
4507 19th Avenue West, Bradenton, FL 34209

This consent authorizes Dr. Morgan to utilize psychometric, psychosexual, psychosocial instruments, personality testing, and/or other inventories necessary to provide a comprehensive evaluation that satisfies the professional and ethical standards of the American Psychological Association (APA), the American Counseling Association (ACA), and the forensic expectations of the court.

I have been informed of the nature and purposes of this service. I have been advised that this examination is confidential, in compliance with HIPAA, and that disclosure of information pertaining to this evaluation will not be released to anyone without my written consent. If a Forensic Mental Health/Trauma Evaluation has been prepared for an attorney, the continued confidentiality of the evaluation will be contingent on the decisions that I and my attorney make regarding disclosure of the report or listing Dr. Morgan as an expert witness in this case. This contingency also applies to Safe Children's Coalition, Child Protective Services, federal or state courts, other official agencies, or any individual in an official capacity associated with or with whom I have granted authority with regard to my case.

I am informed of the statutory exceptions to confidentiality that include suicidal threats, homicidal threats and disclosure of abuse of children or the elderly, or court subpoenas issued by a judge. I understand there is no guarantee that the findings will be favorable to my case, only that they will be objective and truthful.

I understand that Dr. Morgan may consult with Dr. Ronald Aung-Din, a neurologist and psychiatrist, and the staff of the Biblical Counseling Center. I understand that the confidentiality expected of Dr. Morgan applies to those with whom he consults.

I further give consent for my clinical interviews with Dr. Morgan to be audio/video recorded for accuracy of information I submit to him during my clinical interview(s) and quality purposes of the forensic mental health evaluation.

_____	_____
Client's Signature	*Date*
_____	_____
Evaluator's Signature	*Date*
_____	_____
Office Manager's Signature	*Date*

MEDICAL HISTORY Please check (✔) physical, neurological and behavioral conditions you have.

General Physical	Neurological	Behavioral
__ Heart Problems	__ Brain Surgery	__ Weight Gain / Loss (click which)
__ Liver Problems	__ Parkinson's Disease	__ Appetite Changes
__ Lung Problems	__ Brain Injury	__ Bulimia / Anorexia (click which)
__ Allergies	__ Concussion	__ Food Cravings
__ Cancer	__ Stroke	__ Impotence
__ High Blood Pressure	__ Brain Tumor	__ Compulsive Sexual Activity
__ Bowel/Bladder	__ Hallucinations	__ Fatigue
__ Nausea/Vomiting	__ Seizures (including epilepsy)	__ Heat/cold sensitivity
__ Visual Problems	__ Headaches / Migraines	__ Speech Problems
__ Weakness	__ Neuropathic Pain	__ Alcohol Consumption
__ Problems Walking	__ Blackouts	(*description* _____)
__ Unusual Hair Loss	__ Amnesia	(*amount per week* _____)
__ Multiple Sclerosis	__ Headaches	__ Tobacco Usage
__ Menstrual Irregularities	__ Dizziness	__ Insomnia
__ Urinary / Kidney Problems	__ Sensory Distortion	__ Change in Sexual Drive
__ Thyroid Dysfunction	__ Loss of Consciousness	__ Personality Change
__ Diabetes	__ Memory Problems	__ Physical Change
__ Hypoglycemia	__ Episodic Disorientation	__ Constant Hunger
__ Rashes	__ Electro-Shock Therapy	__ Déjà vu
__ Tremors	__ Autism	__ ADD / ADHD
	__ Tourette's Syndrome	__ OCD

List all prescription and over-the-counter medications currently used:

Prescription Medication	Dosage	Prescription Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all non-prescription, over-the-counter medications and vitamin/mineral therapies currently used:

Non-Prescription Medication	Dosage	Non-Prescription Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HISTORY / PROBLEM EVALUATION
BASIC PROBLEM IDENTIFICATION

Please check any of the follow symptoms or conditions you have had or are now experiencing.

CONDITION:	**PAST** *More than 6 months*	**PRESENT** *Less than 6 months*	**CONDITION**:	**PAST** *More than 6 months*	**PRESENT** *Less than 6 months*
Mood high & lows	____	____	Physical abuse from others	____	____
Irritability	____	____	Sexual abuse from others	____	____
Excessive stress	____	____	Excessive worries	____	____
Crying spells	____	____	Difficulty concentrating	____	____
Phobias or fears	____	____	Hearing unseen voices	____	____
Confusion	____	____	Frequent loss of temper	____	____
Low self-esteem	____	____	Acting out violence	____	____
Compulsive behaviors	____	____	Frequent residence changes	____	____
Depression	____	____	Frequent employment change	____	____
Extreme nervousness	____	____	Bed wetting past age 6	____	____
Lack of Motivation	____	____	Fire setting past age 6	____	____
Indecisiveness	____	____	Blaming others frequently	____	____
Loss of memory	____	____	Lack of sexual desire	____	____
Fantasizing	____	____	Compulsive Sexual Activity	____	____
Use of pornography	____	____	Spiritual confusion	____	____
Physical abuse of children	____	____	Thoughts of suicide	____	____
Sexual abuse of children	____	____	Difficulty reading	____	____
Physical abuse of others	____	____	Inability to comprehend math	____	____
Excessive sexual activity	____	____	Inability to express yourself	____	____
			Involvement with the occult	____	____

1. When (approximately) did you have a complete physical examination? _____ Where? _____
2. What physical disorders do you have, if any? _____
   _____
   _____
3. Describe your current relationship to God. _____
   _____
   _____
   _____

SUBSTANCE USE/ABUSE/DEPENDENCE HISTORY

Describe your family of origin's use of alcohol, during your childhood, and how it affected you.

Relationship	*Type of Use/Abuse*	*Treatment*	*How it affected you?*

Describe your own use of alcohol, throughout your lifespan, including any problems that the use/abuse of alcohol has caused, including your current use.

_____

_____

_____

_____

Describe the use of illicit substances and abuse of prescription medications of the members of your family of origin, and how it affected you.

Relationship	*Description of use/abuse*	*Type of treatment*	*How if affected you*

Describe your own use of illicit substances and the abuse of prescription medications, including last and current use.

_____

_____

_____

_____

_____

_____

MENTAL HEALTH HISTORY

Describe the history of mental health issues within your family of origin. ____none

Relationship	*Mental Health Issue*	*Treated or Not Treated*	*How their illness affected you/your Family*

Describe mental health treatment that you have received. ____none

Age	*Diagnosis*	*Type of Treatment*	*Medications prescribed & taken*

[For Office Use Only]

Provisional Diagnoses

Axis I _____
_____

Axis II _____
_____

Strengths: _____
_____

Weaknesses: _____
_____

This client's Treatment Plan should address:

1. _____
2. _____
3. _____
4. _____
5. _____

Date: _____ _____

Harry L. Morgan, Ph.D.
LMHC10635