Patient Name: _____ Patient DOB: _____

Date Completed: _____

## *Patient Intake Form*

PLEASE HAVE THE PATIENT THAT IS SEEKING HELP FILL OUT THIS FORM. If the patient is a minor you may need to assist them, but we ask that each patient does their best to fill everything out to the best of their knowledge. This is designed to gain an understanding of what level of care you need and to assist us in finding the correct provider for you. Thank you.

**Please provide a brief description explaining why you are seeking help. Explain your situation with as many details as possible in order for us to fit you with the correct provider.**

_____
_____
_____
_____
_____
_____

**Please select the type of treatment that you are interested in receiving.**

❑ Psychiatric medication management
❑ Individual counseling
❑ Couples/marriage counseling
❑ Family counseling
❑ Other (please explain) _____

**Please list any medications you are currently or have previously been prescribed. Indicate current or past and dosage.**

| Name of Medication | Dosage | Past or Current |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Who is your Primary Care Physician?**_____

**Are you currently seeing a mental health provider?**

- ❑ Yes (Please provide name/type of treatment) _____
- ❑ No

**Have you seen a mental health provider previously?**

- ❑ Yes (Please provide name, duration of treatment, and reason for termination)

  _____
- ❑ No

**Have you been diagnosed with any of the following? Check all that apply.**

- ❑ Depression
- ❑ Anxiety
- ❑ Adjustment disorder
- ❑ Autism spectrum disorder
- ❑ Bi-polar disorder
- ❑ ADHD/ADD
- ❑ Oppositional defiance disorder
- ❑ Schizophrenia/schizoaffective disorder
- ❑ PTSD- (Post Traumatic Stress Disorder)
- ❑ OCD- (Obsessive Compulsive Disorder)
- ❑ Panic Disorder
- ❑ Other (Please list) _____
- ❑ None of the above

**Please check any of the following that you have experienced in the past six months.**

- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Trouble concentrating
- ❑ Difficulty sleeping
- ❑ Excessive sleep
- ❑ Low motivation
- ❑ Isolation from others
- ❑ Anxiety
- ❑ Low self-esteem
- ❑ Depressed mood
- ❑ Fatigue/low energy
- ❑ Fear
- ❑ Tearful/crying spells
- ❑ Hopelessness
- ❑ Panic
- ❑ Other:_____
- ❑ None of the above

**Are you currently or have you ever experienced any of the following? Check all that apply.**

- ❑ Suicide attempt or gesture (Please provide year and any additional information you are comfortable sharing) _____
- ❑ Actively having thoughts of harming or killing yourself
- ❑ Actively having thoughts or urges to harm others
- ❑ Addiction/Substance abuse issues (Please specify substance/amount/frequency) _____
- ❑ Self-harm either currently or in the past
- ❑ None of these apply to me.

**Have you had any psychiatric hospitalizations within the last ten years?**

- ❑ Yes (Please include year and name of hospital) _____
- ❑ No

**Is there a history of mental illness in your family? If so, please specify.**

- ❑ Yes (Please specify): _____ _____
- ❑ No

**Are you currently involved in legal action of any kind? (Custody, lawsuit, etc)**

- ❑ Yes (Please provide additional details) _____ _____
- ❑ No

**Are you currently seeking medical work leave or FMLA accommodations?**

- ❑ Yes (Please Specify) _____
- ❑ No

**Have you or any family members been seen by any of our providers now or in the past?**
(Please specify patient's name, provider's name, and year they were seen)

_____
_____
_____

_____

_____

_____

_____

_____

***FOR PATIENTS SEEKING COUNSELING ONLY* Do you have a preferred provider?**

- ❑ Male Therapist
- ❑ Female Therapist
- ❑ No preference-first available

**Who completed this form? (If different from patient seeking care):**

_____

**If you are not the biological parent for this patient, do you have legal guardianship to make financial and medical decisions for this person?**

- ❑ Yes
- ❑ No

**IF PATIENT IS A CHILD - Do you have a custody agreement in place?**

- ❑ Yes
- ❑ No
- ❑ Not Applicable

****Please provide custody paperwork prior to scheduling. This includes joint and temporary custody agreements. These documents are required for our providers to provide the appropriate care for you and your family. You may upload these using this portal or email them to us at admin@summervillepsychiatric.com.***

- ❑ I understand I am responsible for providing this documentation prior to scheduling
- ❑ I do not understand
- ❑ I do not have the required documentation
- ❑ Not Applicable

**Please note that our providers do not participate in Disability Claims, FMLA, Worker's Compensation, Court Mandated Counseling, Active Court Cases, or Unresolved Custody Cases.**

- ❑ I understand
- ❑ I do not understand

***Our patient's safety is our first concern. If you feel that you are at an immediate risk of harm to yourself or someone else, please call 911 or visit the closest emergency room. If you do go to the ER, that will not affect your ability to continue care with us. Our office is not an emergency facility and as such, this will always be our first recommendation. Please indicate below that you understand and agree to this policy. Our admin staff will be happy to answer any questions you have regarding our procedures.***

- ❑ I agree
- ❑ I do not understand/agree

***By signing this form, I acknowledge that all information provided is true and correct to the best of my knowledge. I acknowledge that I have received and signed forms from this office, including but not limited to, Fees for Services, Missed Appointment Policies, Notice of Privacy Practices, Practice Policies, and Informed Consent. Additionally, I agree that my signature indicates that I have read, understand, and agree to the items contained in these documents and consent to the treatment of myself and/or child.***

**Patient/Guardian Printed Name: _____**

**Patient/Guardian Signature: _____Date: _____**