HealthLinkNow

PATIENT INTAKE-Adult

Patient ID #:

I. DEMOGRAPHICS

Name: *DOB/Age:*

Email: *Phone:*

Mailing Address:

Location when participating in sessions:

Identified gender: *Preferred language:* *Is an interpreter required?*

Marital Status:

How did you hear about HLN:

II. INSURANCE

Primary Carrier: *SSN:*

Mbr/Subscriber ID: *Co-Pay:*

Secondary Carrier:

Mbr/Subscriber ID:

III. PSYCHIATRIC HISTORY

1. *Are you currently prescribed medications for your mental health? Yes ☐ No ☐*
   If yes,
   a. *Name of medication:*
   b. *Prescribed by psychiatrist or primary care physician?*
   c. *Date of prescription:*

2. *Have you been prescribed medications for your mental health in the past? Yes ☐ No ☐*
   If yes,
   a. *Name of medication:*
   b. *Prescribed by psychiatrist or primary care physician?*
   c. *Date of prescription:*

3. *Have you ever been psychiatrically hospitalized? Yes ☐ No ☐*
   If yes,
   a. *Voluntary or involuntary hospitalization?*
   b. *Length of stay?*
   c. *Dates:*
   d. *Name of facility:*

4. *Have you ever SELF HARMED (cutting, punching, etc.):* *Yes* ☐ *No* ☐
   If yes, please describe:

5. *Have you ever attempted suicide?* *Yes* ☐ *No* ☐
   If yes, please describe:
   Number of attempts:
   Date of most recent attempt:

6. *Have you ever experienced abuse, neglect, or exploitation?* *Yes* ☐ *No* ☐
   If yes, please describe:

7. Have you ever perpetrated abuse, neglect, or exploitation? *Yes* ☐ *No* ☐

8. Would you like a referral for support services? *Yes* ☐ *No* ☐

IV. MENTAL HEALTH HISTORY

1. *Reason for seeking mental health treatment:*

2. *What significant life changes or stressful events have you experienced recently?*

3. *What are your treatment expectations? What do you hope to achieve through treatment (goals)?*

4. *Have you ever participated in mental health treatment (psychotherapy, psychiatric services, counseling, etc)?* *Yes* ☐ *No* ☐
   If yes,
   a. *Dates of treatment:*
   b. *Treatment provider:*
   c. *Reason for treatment:*

V. SUBSTANCE ABUSE HISTORY

5. *Do you use* alcohol? *Yes* ☐ *No* ☐
   If yes,
   a. *How many days per week do you drink?*
   b. *How many drinks typically consumed in that day?*

6. *Do you use any other substances? Yes* ☐ *No* ☐

If yes,

a. *Nicotine/Marijuana:*
Frequency/Amount of use:

b. *Illicit Substances (specify):*
Frequency/Amount of use:

c. *Illicit Substances (specify):*
Frequency/Amount of use:

VI. FAMILY HISTORY

7. *Have any of your family members been diagnosed with a mental illness, addiction or been treated by a mental health professional? Yes* ☐ *No* ☐

If yes,

a. *Relationship of family member:*
Diagnosis or reason for treatment:

b. *Relationship of family member:*
Diagnosis or reason for treatment:

VII. SOCIAL HISTORY

1. *Describe your employment/education status*:

2. *Describe your leisure or recreational activities:*
   a. *How often do you engage in these activities:*

3. Describe your involvement with law enforcement/legal matters within past 12 months:

VIII. MEDICAL HISTORY

1. *Patient has executed an Advanced Directive Yes* ☐ *No* ☐

2. *Primary Care Provider*:

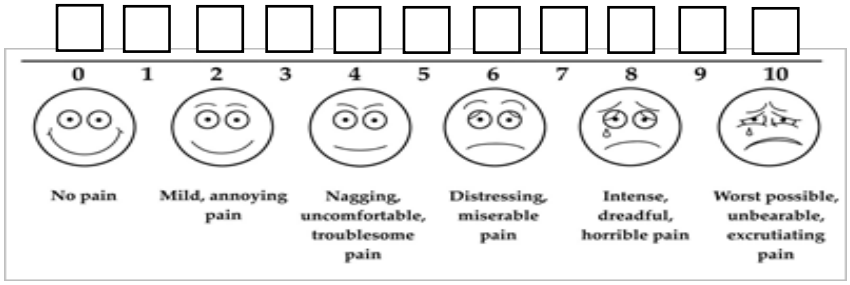
   Address:

   Phone: Fax:

3. *Date of last PCP Physical exam:*

4. *Current Medical problems:*

5. *Current Physical Pain level:*



6. *Weight Change (gain/loss 10 pounds) during past 3 months: Yes ☐ No ☐*
   If yes, explain:

7. *Past or present dental problems: Yes ☐ No ☐*
   If yes, explain:

8. *Allergies to Food or Medications: Yes ☐ No ☐*
   If yes, explain:

9. *Recent decrease in food intake or appetite: Yes ☐ No ☐*
   If yes, explain:

10. *Past/present behaviors of an eating disorder (bingeing or inducing vomiting): Yes ☐ No ☐*
    If yes, explain:

11. *Pharmacy preference:*
    Name:
    Address:
    Phone:

12. *Medical medications taken <u>currently</u>:* (name; dosage; X/day)
    a. *Name of medication:*
    b. *Prescribed by psychiatrist or primary care physician?*
    c. *Date of prescription:*

13. *Medical medications taken <u>currently</u>:* (name; dosage; X/day)
    a. *Name of medication:*
    b. *Prescribed by psychiatrist or primary care physician?*
    c. *Date of prescription:*

14. *If your last PCP appointment was longer than 12 months ago or if you are experiencing medical concerns including those mentioned above, would you like assistance setting up an appt with your PCP: Yes ☐ No ☐*

Check all Services you are interested participating in:

- ☐ *Psychiatric Medication Management*
- ☐ *Therapeutic*
- ☐ *Couples Therapy*
- ☐ *Group Therapy:*
  - ☐ *Depression*
  - ☐ *Anxiety*
  - ☐ *Stress management*
  - ☐ *Occupational problems*
  - ☐ *Anger management*
  - ☐ *Past traumas*
  - ☐ *LGBTQ*
  - ☐ *Self-esteem*
  - ☐ *Covid-19 Coping Skills*
  - ☐ *Other:* _____
  - ☐ *Other:* _____

Leave this section blank, for HLN office use only:

Patient Health Questionnaire
(PHQ - 9)

Date Completed (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

Time of Administration:

☐ Admission
☐ During Treatment..... { ☐ Days ☐ Weeks ☐ Months } since Admission ☐☐
☐ Discharge

Be sure to fill in all choices with ☒ **not** ☑

Over the last week, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Please place an X in the box below your answer.	0	1	2	3
1. Little interest or pleasure in doing things	☒	☐	☐	☐
2. Feeling down, depressed, or hopeless	☒	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☒	☐	☐	☐
4. Feeling tired or having little energy	☒	☐	☐	☐
5. Poor appetite or overeating	☒	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☒	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☒	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☒	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☒	☐	☐	☐
For office coding:	0 +	___ +	___ +	___

= TOTAL SCORE: ☐☐

(add up each item)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Patient Account Number

☐101 Program Code

17863

HealthLinkNow

Mental Health Resources

If you or someone you know is in need of urgent or in-person mental health services please utilize the following resources:

Emergency Services:

Dial 911 or go to your nearest **Emergency Room**

If the situation is potentially life-threatening, get immediate emergency assistance by calling 911, available 24 hours a day.

National Suicide Prevention Lifeline:

Dial : 988

Trained crisis workers are available to talk **24 hours a day, 7 days a week**. Your confidential and toll-free call goes to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals.

Find in-person mental health services by visiting:

https://www.findbhhelp.com/